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ABSTRACT

These conference proceedings contain presentations related to child abuse and neglect among American Indians and mental health issues for emotionally disturbed American Indian children and adolescents. Specific topics include: (1) tribal mental health programs; (2) child abuse prevention and intervention; (3) child rearing programs to fight child sexual abuse; (4) problems with child protective service agencies who are non-natives; (5) community approaches to family preservation; (6) implementation of the Child Welfare Act; (7) a wellness program integrating aerobic dance with American Indian health philosophy; (8) reunification of children into their communities after foster care; (9) a program for developmentally delayed Indian children and their parents; (10) Minnesota Indian Family Preservation Act; (11) post traumatic stress disorder; (12) case application for tribal court judges developing and using protocols in child abuse and neglect; (13) post traumatic cultural disorder; (14) classes and counseling for teen parents; (15) child abuse and mental health legislation affecting Native Americans and Alaska Natives; (16) a program to prevent alcohol and substance abuse; and (17) a peer intervention and prevention group process. Names and addresses of presenters are included. This document contains graphics, tables, bibliographies, and excerpts of legal documents. (KS)

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UNITING OUR CONCERNS

DATE:	April 22-24, 1991
LOCATION:	Minneapolis, Minnesota
SPONSOR:	American Indian Institute Continuing Education & Public Service University of Oklahoma Anita Chisholm, Director 555 Constitution Street Norman, OK 73037-0005 (405) 325-4127
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ON THE COVER

Children of the American Indian Institute staff

From left to right:

Maké Samuel Ross
John A. Gilbert, Jr.
William Fish
Jared Fish
Steven L. Gilbert
Louis Dekeneks Ross
Terry Holloway
Karen Fish

Center:

Danielle R. Gilbert

UNITING OUR CONCERNS

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AMERICAN INDIAN COMMUNITY AWARENESS: A CAMPAIGN TO COMBAT CHILD ABUSE AND NEGLECT WILDFIRE

K. T. 'Hut' Fields, M.S.W.
Coordinator
Three Feathers Associates
Norman, Oklahoma

AMERICAN INDIAN COMMUNITY AWARENESS: A CAMPAIGN TO COMBAT CHILD ABUSE AND NEGLECT (WILDFIRE)

K. T. "Hut" Fields

"General opinion has held that child neglect is a problem in Indian communities, however, the existence of physical or sexual abuse has been downplayed. As a result of resent training and education programs and the amount of contemporary social service systems, tribal communities are recognizing that they are not exempt from the problem of physical and sexual abuse" (Linkages, 1987).

The limited information that does exist indicates that American Indian populations experience child abuse and neglect at approximately the same rate as non-Indian populations (National American Indian Court Judges Association, 1985). A recent report released by the Bureau of Indian Affairs (BIA) provides information on the incidence of child abuse and neglect within Indian communities throughout the Nation. The BIA report indicates that of the 19,918 child abuse/neglect cases reported during FY 1986, seventy percent were neglect cases; nineteen percent were physical abuse cases; and eleven percent involved complaints of sexual abuse. Eighty-two percent of the reported cases were substantiated (Linkages, June 1987).

The BIA - Division of Social Services, views this information to be a low estimate of the actual number of cases reported on or near reservations. Nevertheless, the report does show there is a significant increase in reported physical and sexual abuse cases within Indian communities where child welfare programs are operated.

Another study conducted during 1986/1987 supports the BIA findings and provides additional information on the incidence of child abuse/neglect within American Indian populations. Data from a study conducted by CSR, Incorporated and Three Feathers Associates reveals that of 7,270 Indian children in substitute care (Public Welfare, Tribal Welfare, BIA System) 12.5% were abused or molested and 35.7% were neglected (Native American Children in Substitute Care, 1988).

Both sources of information indicate that greater community awareness is a primary factor accounting for the increased reporting of child abuse within Indian communities. The level of community awareness concerning the incidence of child abuse and neglect varies. Indian communities are at various stages in addressing the issues of child maltreatment. Definitions of child abuse vary from one Indian community to another; from one tribe to another. Using Henry C. Kempe's model of community awareness (1977), an increased number of Indian communities are leaving Stage II in which child abuse is considered rare and newsworthy and are entering Stage III; the recognition of the Battered Child Syndrome. More and more attention is being paid to early detection and intervention in cases of physical abuse, and there is a beginning awareness of the serious effects of emotional abuse neglect upon Indian children.

A Delphi Survey was distributed by Three Feathers Associates to a stratified random sample of Indian social service providers across the United States to clarify tribal definitions of and attitudes toward child abuse and neglect in Indian country. Findings of the study indicate that a major causal factor of abuse and neglect within Indian communities is the loss of traditional values in child rearing practices (The Government Boarding School Syndrome). Other factors evident are stress due to poverty or unemployment, the loss of self-esteem and substance abuse.

The purpose of the Delphi Survey was to collect consensus data on cross-cultural definitions of child abuse and neglect in Indian country for use in developing a multi-media campaign to combat the problem. The multi-media campaign has been developed and contains training curricula for tribal program personnel, a training video, brochures, newspaper articles for local dissemination, radio public service announcements and television public service announcements. The television public service announcements are of broadcast quality and may be used by tribal programs for viewing on their local television network.

Many Indian communities are not aware of the problems that child abuse and neglect present. Some fail to recognize the need for the community to become involved; some communities, Indian or

not, prefer to look that other way. Many Indian communities expect inadequately funded tribal child welfare programs to be responsible for both the prevention and intervention in cases of child abuse and neglect. Through this project, there is now an avenue for Indian organizations and tribal programs to developed on-going community awareness programs to combat the problem.

Cultural barriers exist which inhibit child protection agencies in their efforts to combat the problem of child abuse and neglect within American Indian communities. A major barrier has been the lack of agreement on clear-cut definitions of Indian neglect and abuse that cut across multiple cultural boundaries. "Each tribal community, based upon their cultural beliefs and values, may legitimately define child abuse and neglect differently than the standards of acceptable conduct within the broader society (Kempe & Helfer, 1980)." The products developed by this project have improved the ability of state and local Native American social service personnel to work toward becoming skilled in cross-cultural social work practice. The project takes into account that American Indians are culturally diverse and have differing beliefs and values that have affected their traditional and contemporary child rearing practices.

Three Feathers Associates - **American Indian Community Awareness: A Campaign to Combat Child Abuse and Neglect (WILDFIRE)** is beginning to bridge some of the gaps that are evident in the protection of children. The working arena of child protective services within Indian communities is complex. This creative and innovative method of building community awareness and initiating prevention projects was designed so that both experienced professionals and workers new to the field can be equally involved.

Native Americans must become involved in meeting the challenges that child maltreatment present, both within their own communities and the broader systems that affect Indian children. This project is such an endeavor.

THE ANATOMY OF A TRIBAL MENTAL HEALTH PROGRAM

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THE ANATOMY OF A TRIBAL MENTAL HEALTH PROGRAM

John G. Jones
Dianalee Skeen

This paper will address the challenges set forth in the planning, implementation and operationalization of a tribal-wide mental health program. The environmental setting, political climate, facilities, existing programs, demographic data and clinical challenges are among topics to be considered as we explore these three phases of development of the initial mental health program in the illustrious history of the great Creek Nation.

I. PLANNING

This particular program had its inception in a rather serendipitous manner. The IHS area director of mental health programs came into some money at about the same time that a fully-qualified psychologist chose to return to his rural roots and that the Creek Nation Health Care System's (CNHCS) board and administrator were exploring providing a wider, more comprehensive level of health care for its people. This unusual trio all came to an agreement and the initial seeds of a mental health program were sown.

The IHS area mental health manager advised the IHS project manager of CNHCS of his intent to fund a mental health program. The project manager was the key player during the planning and implementation phases of the program. She served on the committee that developed the scope of work, wrote the position descriptions, ordered the supplies and equipment, and made sure all the "official" paper work regarding funding was properly done. One particularly vital role she played was ensuring the employment of the quality of mental health care professionals needed (educationally, experientially and training-wise) for this unique and challenging task. This assurance, built into the scope of work and position descriptions, guaranteed the CNHCS of a high caliber, mental health program from its inception.

While there was general agreement that a mental health program was needed, the questions of who, how, what, where, and when, were unanswered. The decision was made at this point to authorize a needs assessment and feasibility study, to be conducted by the psychologist that was to eventually head the program. This was a crucial point, and a highly recommended approach, far superior to having an independent party conduct such a study. Insights were gained, attitudes sensed, priorities established, needs identified, and networking systems explored; all of which became essential foundation data for the implementation phase.

The feasibility study took some seventy-two hours over about a three week period. It consisted of visits to and familiarization with the following institutions, programs, and people: tribal administration; tribal social services program; tribal Head Starts; the tribe's three IHS clinics and clinic directors; tribal operated hospital; all clinic and hospital physicians; Indian educators in public schools; counselors and school administrators in towns and cities located within tribal geographic boundaries; tribal child welfare programs; CNHCS board members and administrators; Creek Nation national council members; local city, county, state, and private mental health care agencies; local service committees; tribal community meetings; IHS program manager for CNHCS; and the IHS area mental health manager. The results of the survey and assessment are contained in Appendix A, and summarized here:

1) Staff in-services training, with emphasis on early recognition of mental problems, child abuse and substance abuse
2) Stress management
3) Familial discord
4) ADHD/ADD/learning disabilities
5) Suicide and other self-destructive behavior
6) Staff stress management
7) Psychological consultation
8) Alcohol and substance abuse
9) Public awareness of services
10) Education/prevention programs

11) Early recognition and intervention in the area of developmental disorders

12) Depression

13) Anxiety

14) Consultation with public schools

15) Stress-related diseases

16) Marital discord

17) On-call psychological services

The decision was made to make the program as comprehensive as possible. The primary factors considered were staffing level, staff qualifications, and specialty areas. The following direct services were determined apropos:

I. Psychotherapy
   A. Individual
   B. Group
   C. Marital
   D. Family

II. Psychodiagnostics
   A. Psychological Testing
   1. Intellectual
   2. Developmental
   3. Personality
   4. Academic
   5. Specialty (Suicide, ADD, etc.)
   6. Psychomotor
   7. Visual Motor

   B. Diagnostic Interview

III. Education/Training
   A. Parenting
   B. Prevention
   C. Stress management
   D. Staff development

IV. Consultation

V. Specialty Areas
   A. Expressive therapy
   B. Neuropsychology

The population served proved yet another challenge! The Creek Nation subsumes a range of people varying from the wealthiest suburbs of Tulsa, Oklahoma, to the most rural, poverty-stricken areas of rural Oklahoma. There are the urban, suburban, and the ultimate rural, and all stations in between. This also indicates a wide variety of schools, agencies, support systems available, and degrees of sophistication.

Given the information and signs of the time, the decision was made to make a clinical presence felt first, and to go into the less clinical dimensions later. This proved to be a sound, wise decision. It got the program established immediately, gave it exposure to the people and medical staff, and allowed the psychology staff to have an immediate positive impact. Policies, prevention, education and training followed. First and foremost, however, the recognition as a clinical program was ingrained and accepted.

II. IMPLEMENTATION

To facilitate the establishment of a functional clinical program, a workable delivery system had to be established at four delivery sites (three clinics and a hospital). The following procedures and arrangements were established at each treatment site:

1) Referral procedures
2) Appointment procedures
3) Telephone procedures
4) Office space
5) Testing space
6) Storage space (test materials, art therapy supplies, toys, etc.)
7) Familiarization of clinic staff with nature of program
8) Billing procedures (procedures codes, diagnosis, etc.)
9) Follow-up procedures
10) Forms (initial evaluation, treatment plan, discharge summary, demographic data sheets)
11) Out-of-clinic referral sources
12) Networking procedures for local and state agencies, as well as other Native American agencies, treatment centers and hospitals
13) Psychiatric consultation (for Behavioral Health staff)
14) Close liaison with IHS clinic doctors and hospital doctors
15) Staff acceptance and confidence

Another important implementation step was to integrate the mental health program with existing programs, particularly the health, substance abuse, social service, and child welfare programs of the tribe. This was accomplished by personal contact, open discussion, and the arrival at an understanding as to what each program was about. This effort established a mutual respect and arrived at a common goal,which was, to form a close-knit team working toward betterment of the tribe, through improved mental health.

A key issue was to gain acceptance, both as individuals and as mental health professionals. Of primary concerns was the more rural, traditional and full-blood people. The following techniques proved useful in spreading the word about the new program. In this tribe, word-of-mouth is an extraordinarily rapid communication technique. Also, announcements were made in tribal and other Indian newspapers; presentations were made at tribal community meetings; conferences and pow-wows were attended; meetings with Indian educators and local school counselors and principals were held. Local service committees and child protective teams also proved to be valuable resources for getting acquainted.

III. OPERATIONALIZATION

It is apparent to the reader that, by choosing to start clinical work immediately (one week after the psychologist was hired, patients were being seen in all three clinics!), operationalizing was an on-going process. Both the theoretical and practical aspects of operationalizing the program will be discussed.

Theoretical Aspects

Several aspects were able to be put into place, because of the newness of the program, the support of the administration, and the data gathered in the needs assessment.

1) Having both a male and female psychologist available, thereby giving patients a gender preference.

2) Staff with varied training and theoretical backgrounds.

3) Staff with both roots and interest in rural life and minority populations.

4) Staff with training, experience and certification, in areas known to have specific application to Native American populations, such as expressive therapy (with an emphasis on art therapy) and neuropsychology (with an emphasis on child neuropsychology).

5) Availing staff of necessary equipment and materials to actualize and utilize their training and experience, both general and specialized.

6) Built in opportunity for research, training practice that would make the positions attractive and challenging to the quality of professionals wanted by the program manager and tribe.

7) Assure and ensure the opportunity for the individuality of the professionals to be expressed in their service delivery.

Practical Aspects

These are the nuts and bolts aspects that must be attended to early on.

1) Selection and ordering of tests, materials, equipment, furniture, etc.

2) Determining work schedules, rotations, who goes where and when. For instance, each psychologist goes to each clinic each week, on different days providing maximum service delivery with minimal personnel.

3) Working out administrative details in three clinics and a hospital, all of which do their records differently, put behavioral health data in different places in the chart, etc.

4) Making sure we have an office on days we are in the clinic.

5) Training receptionist and secretaries how to schedule, re-schedule, handle emergencies, etc.

6) Working out chart entries, availability of charts, confidentiality of charts, etc.

7) How to treat staff and what to do about recording their clinical data in the chart.

8) Travel

9) Training

10) In-service training

11) Teaching "techniques" for making mental health referrals.

12) Paper work routines, especially when you are out of your designated work station forty to fifty percent of the time.

13) Establish emergency referral and intervention procedures.

14) Establish policy, procedures, quality assurance, evaluation, monitoring and reporting systems.

While the elements mentioned in the theoretical and practical aspects above are generally self-explanatory, two dimensions of specialization merit brief elaboration. These are the art therapy and neuropsychology embraces several dimension. One of our primary concerns was the use of drugs and alcohol, and particularly, inhalants by the general population. The early detection of brain dysfunction as a result of substance abuse and associated trauma, has clear implications for treatment and rehabilitation programs. A more specific concern was substance abuse by pregnant women, especially the young, teenage women. There is also a significant population of alcoholism among older women, and neither of these populations necessarily avails itself of prenatal care. The results is a wide range of insults to the fetus, resulting in everything from fetal alcohol syndrome to hyperactivity. The ability to identify these dysfunctions as early as possible have long-term implications for school placement, parental education, and the development of expectations for these children. These are but two of the compelling reasons for having a thorough neuropsychological component to this program.

The use of expressive therapies was planned as a necessary component to this program from the beginning. Of particular emphasis are play therapy and art therapy. Play therapy's appropriateness and effectiveness is well documented. As children express and work through their concerns and developmental issues through play, play therapy becomes an integral part of both their assessment and treatment.

Art therapy is an expressive modality that uses non-verbal graphic communications, symbol, and metaphor to assist in the identification and resolution of conflict or problems. Native American Cultures are very visual in nature and their traditions support the use of symbols. Additionally, art therapy processes tend to circumvent guardedness and defenses, allowing patients, even those with minimal verbal skills, to utilize a therapeutic situation.

IV. SUMMARY

The step-by-step process for establishing a mental health program in a widely diversified tribal population, scattered over a large geographical area, was presented. The planning, implementation and operationalization phases were outlined. An important dimension of this program development was the needs assessment study accomplished before the actual start-up of the program. It was felt that two other vital aspects were the consideration of the special needs of the tribe, taking into account Native American tradition, and, having the ability to implement the program to meet those needs. The other key dimension in this program was the support of the program manager and the tribal administrator (health care) in insisting on retaining the best available staff with the qualifications, training, experience, and specialty abilities to initiate the quality of program that the tribe was deserving of having.

APPENDIX A

Date: April 16, 1990
From: John G. Jones, Ph.D.
To: Health Programs Coordinator, Health Board, Clinic Directors, Physicians and Staff
Subj.: Results of Needs Assessment Survey

I would like to thank each of you for the time you took from your busy schedules to meet with me and discuss your ideas and concerns regarding the establishment of a mental health program. I was most encouraged and excited about the possibilities and the receptiveness of everyone I spoke with during my interviews.

Following is a list of the needs submitted by those with whom I spoke. This is considered a preliminary list, and I would greatly appreciate it if you would review it, make additions, corrections, other suggestions, and ideas and re-submit it to me. I did not get to speak with everyone, and I am sure there are many other good ideas that are not included. Remember, no idea is bad. We want to hear from all of you and your suggestions are valuable to us.

These needs are not necessarily listed in a priority ranking. I will leave plenty of space for corrections, modifications, and additions. At this point, nothing is written in stone, so now is the time for all that input you have always wanted to have!

1) Staff in-service training. Subjects to include, but not limited to: child abuse, recognition of mental health problems, substance abuse, when to make a referral, etc.

2) Stress management (financial, as a result of ETOH/substance abuse, family discord, etc.)

3) Family problems

4) ADHD/ADD/learning disabilities

5) Suicide and other self-destructive behavior

6) Staff stress management

7) Consultation availability (necessity of being available for consultation on days when we are not in the clinic)

8) Alcohol and substance abuse

9) Public (tribal and referral sources) awareness of available services.

10) Educational programs, primarily aimed at prevention.

11) Early recognition of developmental disorders, and subsequent intervention.

12) Depression

13) Consultation with public schools.

14) Anxiety

15) Stress-related diseases

16) Marital problems

17) On-call services for staff, board members, and medical director!!!

Please review these and, as mentioned, all other suggestions and ideas are more than welcome.

Thanks again for your cooperation and I am looking forward to working with each of you.

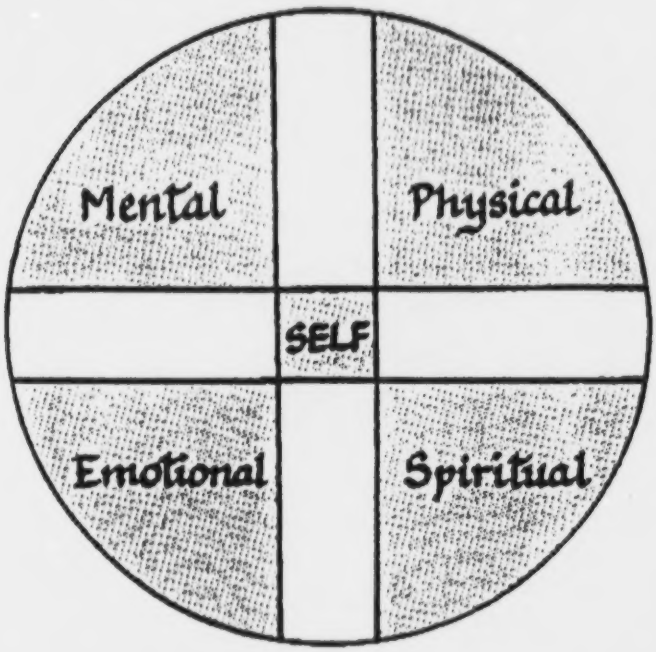
CIRCLES OF LIFE

Georgia Fox
Youth Counselor
Circle of Life
Treatment Center for Youth
New Town, North Dakota

CIRCLES of LIFE

Presented and Developed by Georgia Fox

Restoring the Spirit
With Healing Colors of the Rainbow

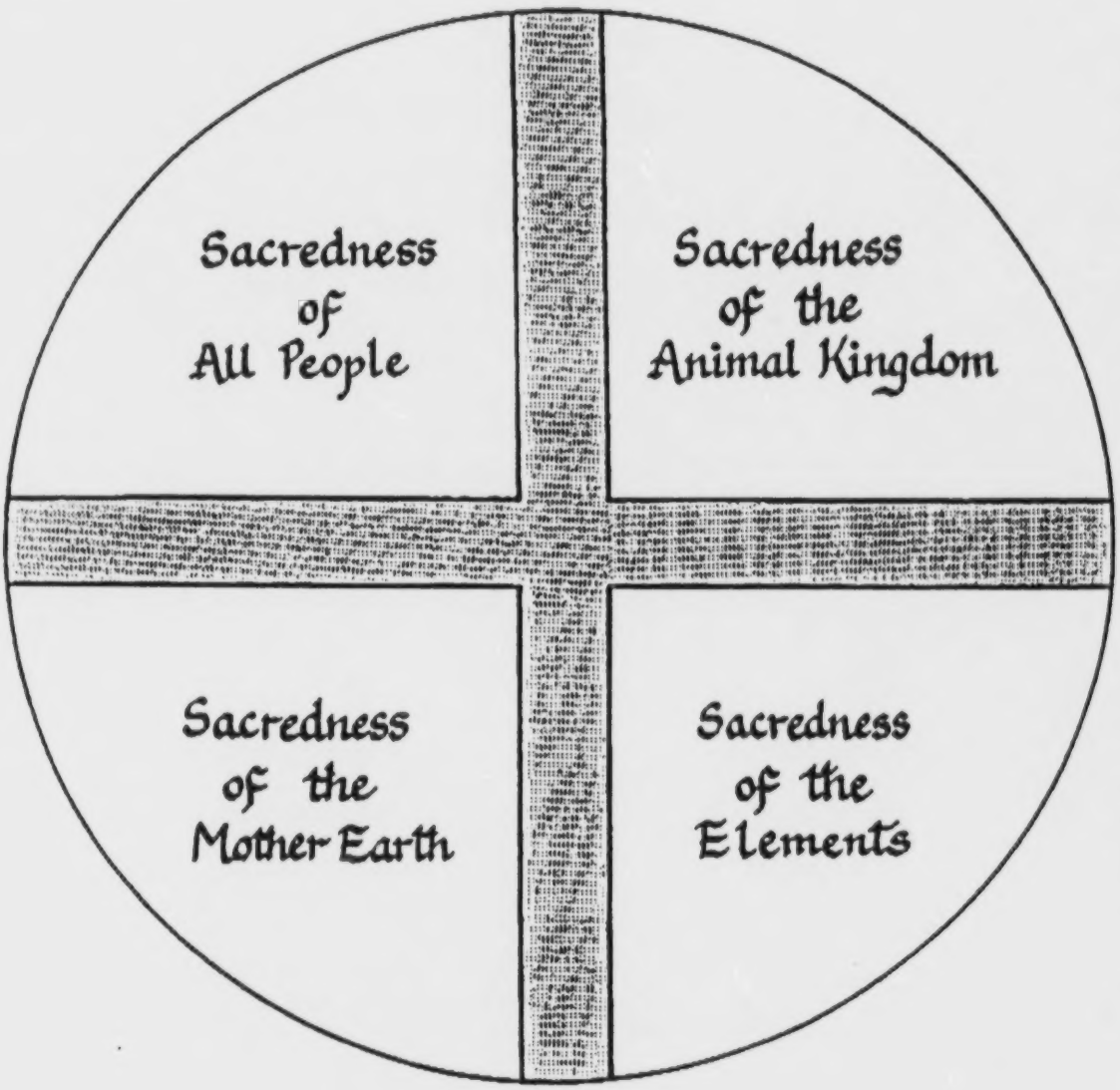


Discover the Sacred Circle
and Honor the Gifts of Self

Circles of Life based on personal life experiences and struggles.
To Spiritual teaching and healing.

© GF 1985

A Sacredness in all Creation



Everything has a reason and purpose.

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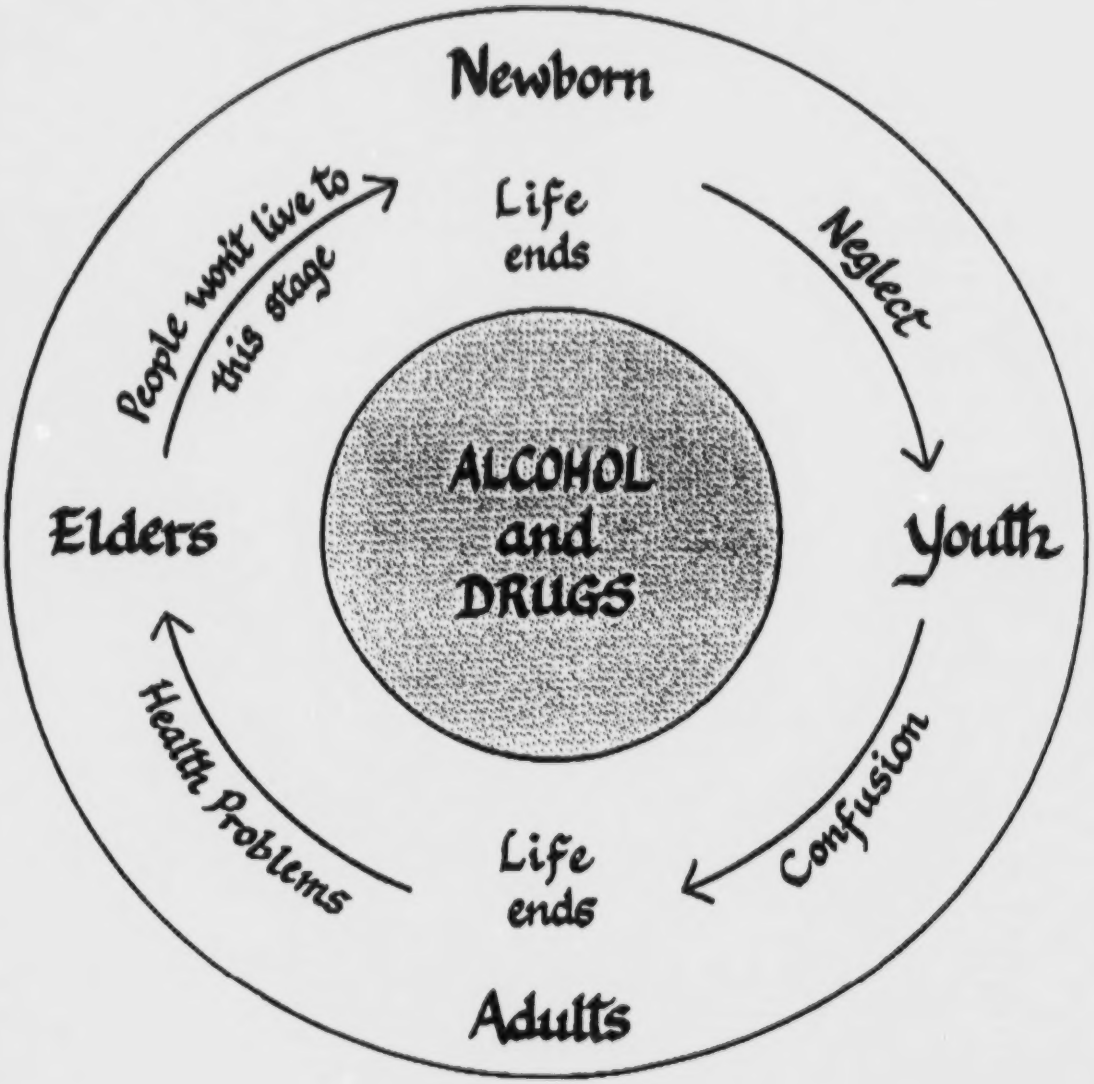
When ALCOHOL and DRUGS enter the lives,
People don't complete their Circle of Life.



Difficulties:
Alcohol destroys the ability of a person to live a positive, creative life.
The Sacred Circle is disrupted.

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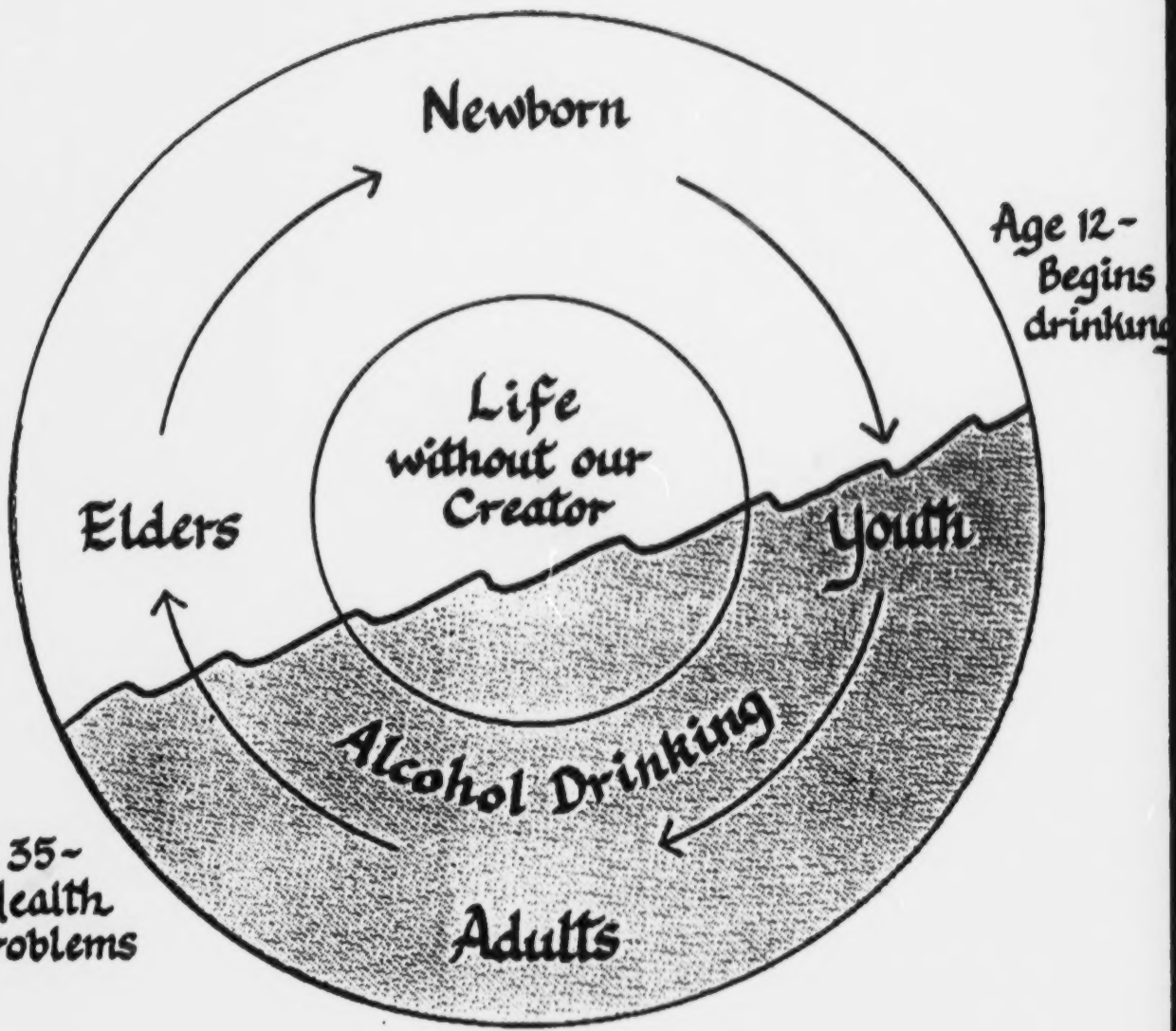
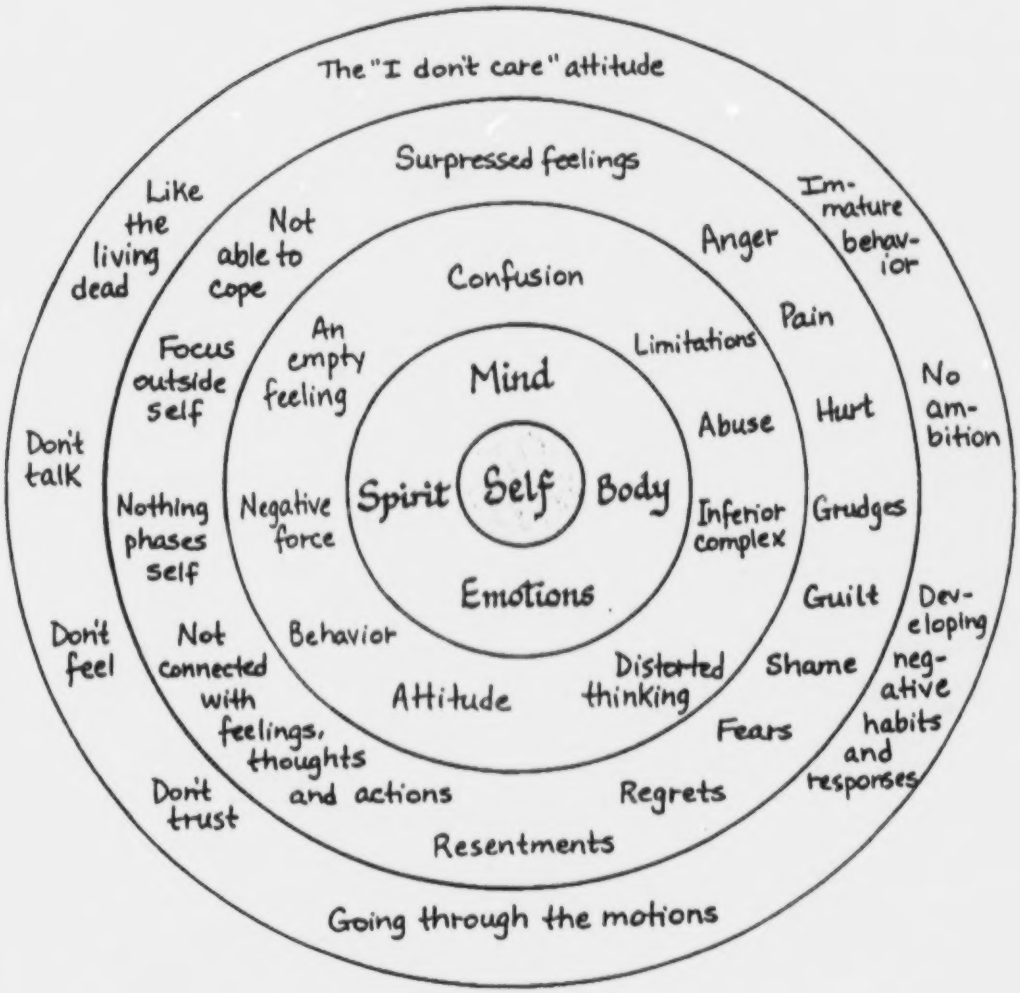
Life without our Creator



Life is just beginning and ENDING.
Many are losing their lives between age 12 and 35.

©

"SELF" consists of Four Concepts



Focus outside self

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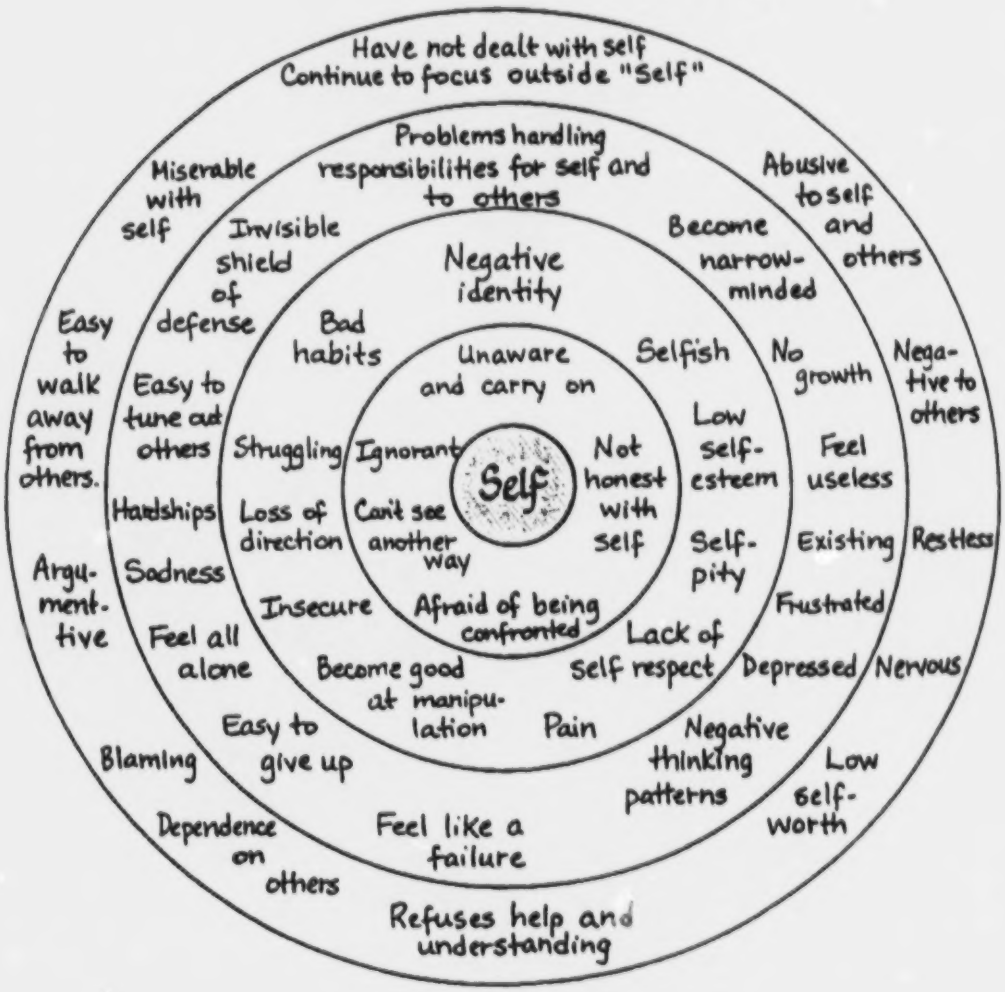
Circle of Life - Problems coping

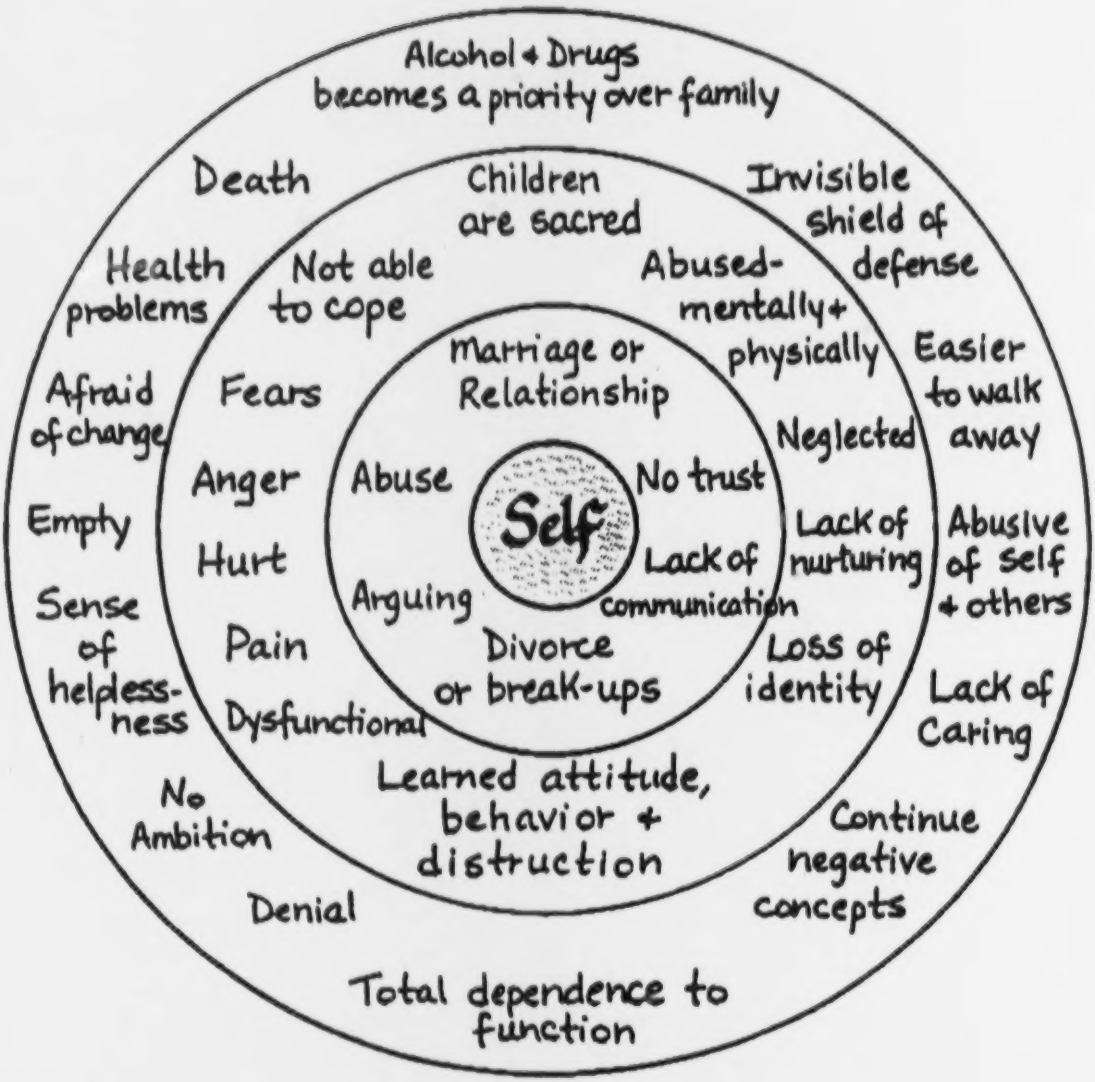


One's own enemy is self.

Only self can change.

© Gross

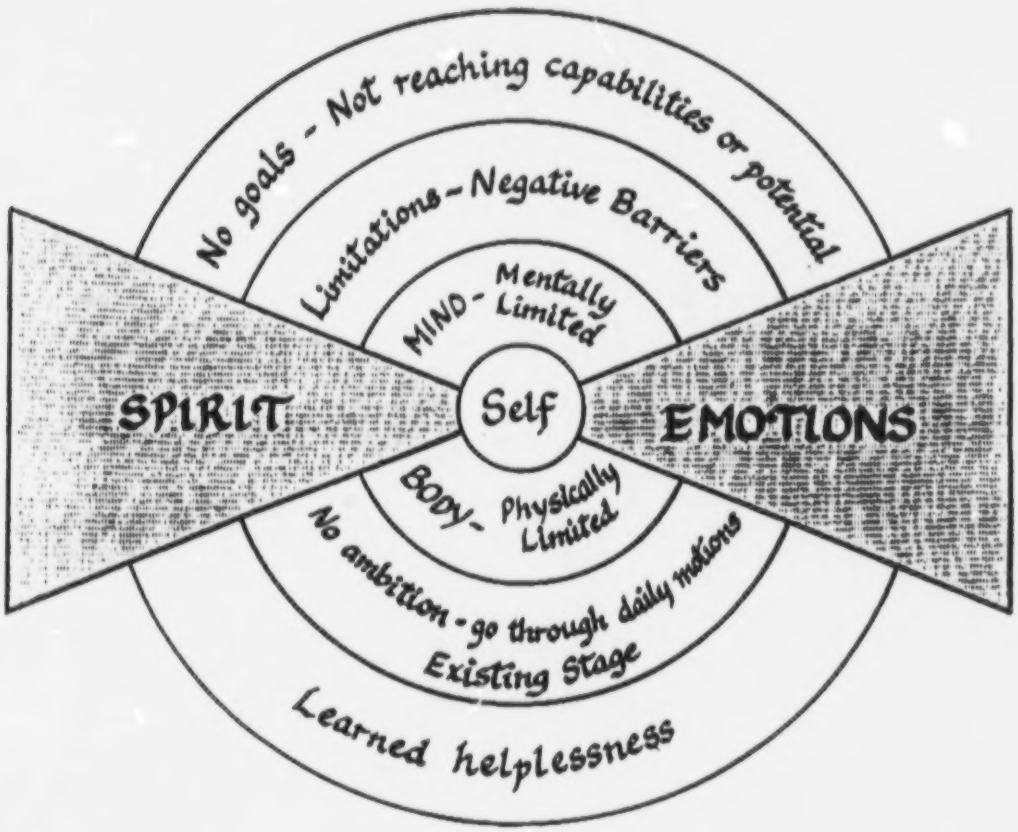
Circle of Life ~



A family unit where everyone is affected/afflicted.
Life of chaos.

© GF 1985

Circle of Life not complete~
Self-limiting barriers



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What Do WE Do with Our feelings ?

Hard & Difficult Feelings

* REGRETS
* FRUSTRATIONS
* ANGER
* CONFUSION
* JEALOUSLY
* HATE
* SHAME
* GUILT
* LONELINESS
* PAIN
* HELPLESSNESS
* HURTS
* POWERLESSNESS
* GRIEF
* WORTHLESSNESS
* FEARS
* CRITICISMS
* SADNESS
* LOSS OF SELF RESPECT
* DEPENDENCES
* SELF-PITY
* SUFFERINGS
* LOW SELF-ESTEEM
* OBSTACLES
* DEFENSES
* DEPRESSION
* IGNORANCES
* HOPELESSNESS
* EMPTINESS
* VOIDS
* TEARS
* LIMITATIONS
* RESTLESSNESS
* MISERABLE
* SICKNESSES
* MADNESS

(WE STUFF OUR FEELINGS)

(WE STORE OUR FEELINGS)

(WE CARRY OUR FEELINGS)

(WE BOTTLE UP FEELINGS

Good & Pleasant Feelings

* LAUGHTER
* HUMOR
* LOVE
* GLAD
* SERENITY
* FRIENDSHIPS
* COMPASSION
* CARING
* SHARING

* THE HARD/DIFFICULT FEELINGS OUT-WEIGH THE GOOD FEELINGS PEOPLE CAN IDENTIFY AND RELATE BECAUSE THEY CARRY ALOT MORE OF THE HARD AND DIFFICULT FEELINGS INSIDE.
* THE DYSFUNCTIONAL RULES OF DON'T TALK, DON'T FEEL, DON'T TRUST STOPS US.
* WE CAN CARRY THESE FEELINGS INSIDE SO LONG THAT THEY SURFACE AND SURFACE, YET WE REFUSE TO DEAL WITH THEM. WE KEEP PUSHING THEM DEEP DOWN INSIDE TILL WE NUMB OUT TO THEM AND DON'T KNOW WHAT WERE FEELING.
* WE CAN CARRY THESE FEELINGS FOR (20) TO (40) YEARS OR MORE, FOR SOME PEOPLE WILL CARRY THESE TO THEIR GRAVE.
* THE HARD AND DIFFICULT FEELINGS REFLECT IN OUR OWN BEHAVIORS, ATTITUDES AND OUTLOOK ON LIFE. IF WE CAN'T SEE GOOD WITHIN OURSELVES IT BECOMES DIFFICULT TO SEE THE GOODNESS ABOUT OTHERS.
* HOW WE CARRY OURSELVES AND PRESENT OURSELVES IS A REFLECTION OF WHATS GOING ON INSIDE. YET WE CAN BE GOOD TO OTHERS BUT HARDER ON OURSELVES, CHILDREN AND FAMILIES.
* WE CAN CONTINUE TO ACCUMULATE MORE UNRESOLVED FEELINGS AND FIND IT DIFFICULT TO UNDERSTAND TO "LET GO" AND LET GOD".

THE Hard and Difficult feelings Out-wergh the Goodness Because we have not Learn to Let Go and Let GOD. WE Don't Understand and Continue to harder on Ourselves.

Hard & Difficult feelings

* REGRETS
* FRUSTRATIONS
* ANGER
* CONFUSION
* JEALOUSLY
* HATE
* LONELINESS
* SHAME
* GUILT
* PAIN
* HELPLESSNESS
* HURTS
* POWERLESSNESS
* GRIEF
* WORTHLESSNESS
* FEARS
* CRITICISMS
* SADNESS
* LOSS OF SELF-RESPECT
* DEPENDENCES
* SELF-PITY
* SUFFERINGS
* LOW SELF_ESTEEM
* OBSTACLES
* DEFENSES
* DEPRESSION
* IGNORANCES
* HOPELESSNESS
* EMPTINESS
* VOIDS
* TEARS
* LIMITATIONS
* RESTLESSNESS
* MISERABLE
* SICKNESSES

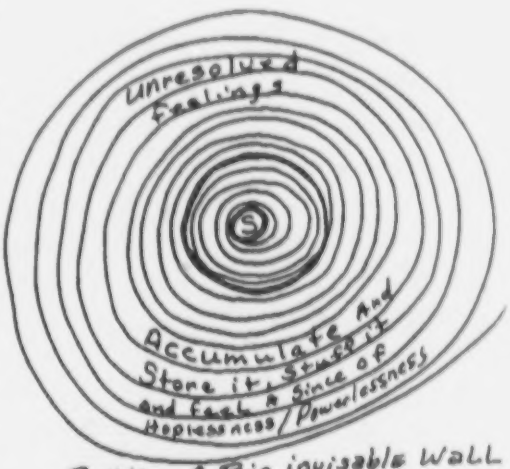
OUR FEARS ARE DON'T TALK, DON'T TRUST, AND DON'T FEEL. NUMBING- OUT.

BARRIERS

(WE STUFF OUR FEELINGS) (WE STORE OUR FEELINGS) (WE CARRY OUR FEELINGS) (WE BOTTLE UP FEELING

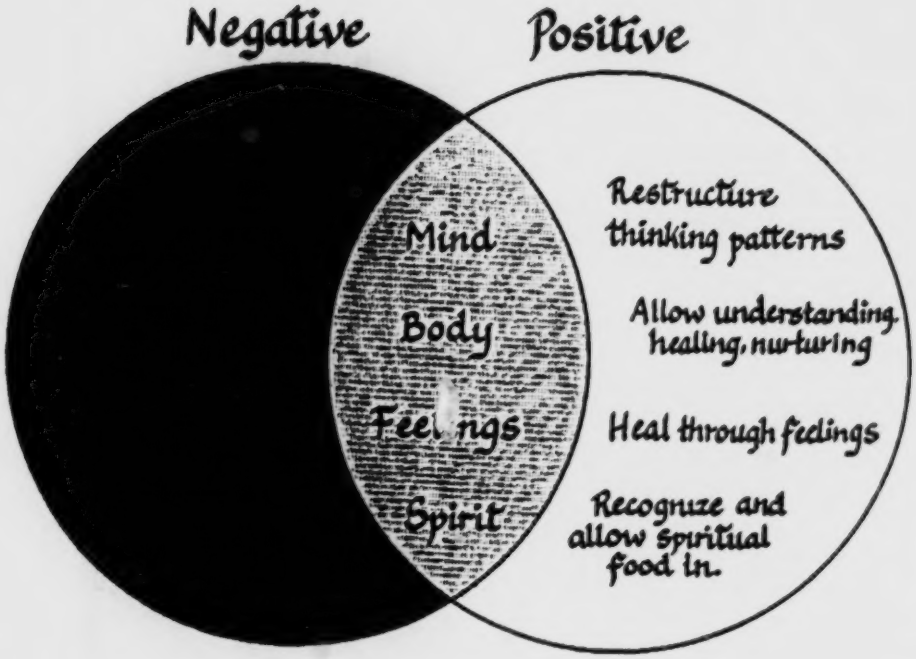
Good and Pleasant feelings

* HUMOR
* LOVE
* FRIENDSHIPS
* CARING
* SHARING



Building A Big invisable WALL Around Ourselves.

Unbalanced



No healing allowed Neglectful

Allowing changes, healing and nurturing

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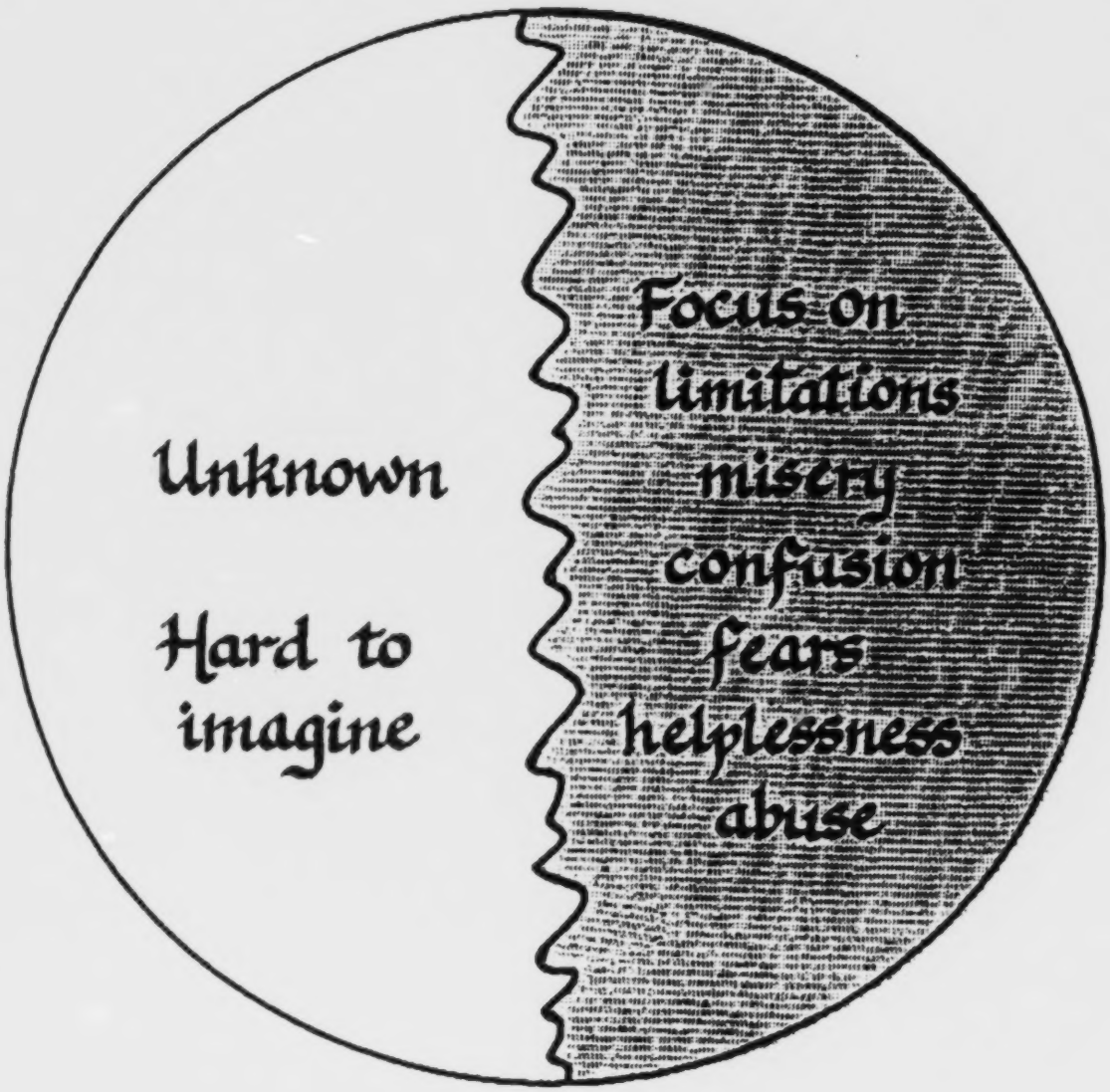
Circle of Life People Choose NOT to complete



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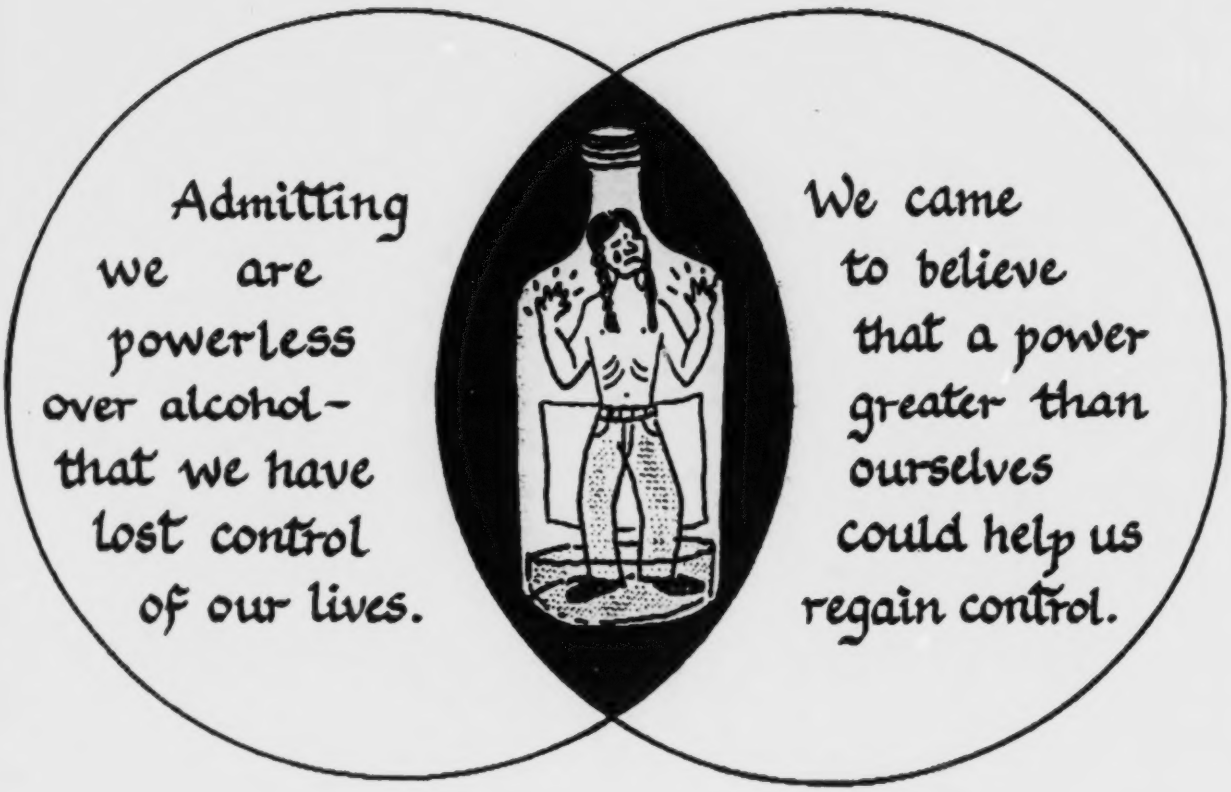
The First Step of A.A.


Admitting we are powerless over alcohol- that we have lost control of our lives.
We came to believe that a power greater than ourselves could help us regain control.

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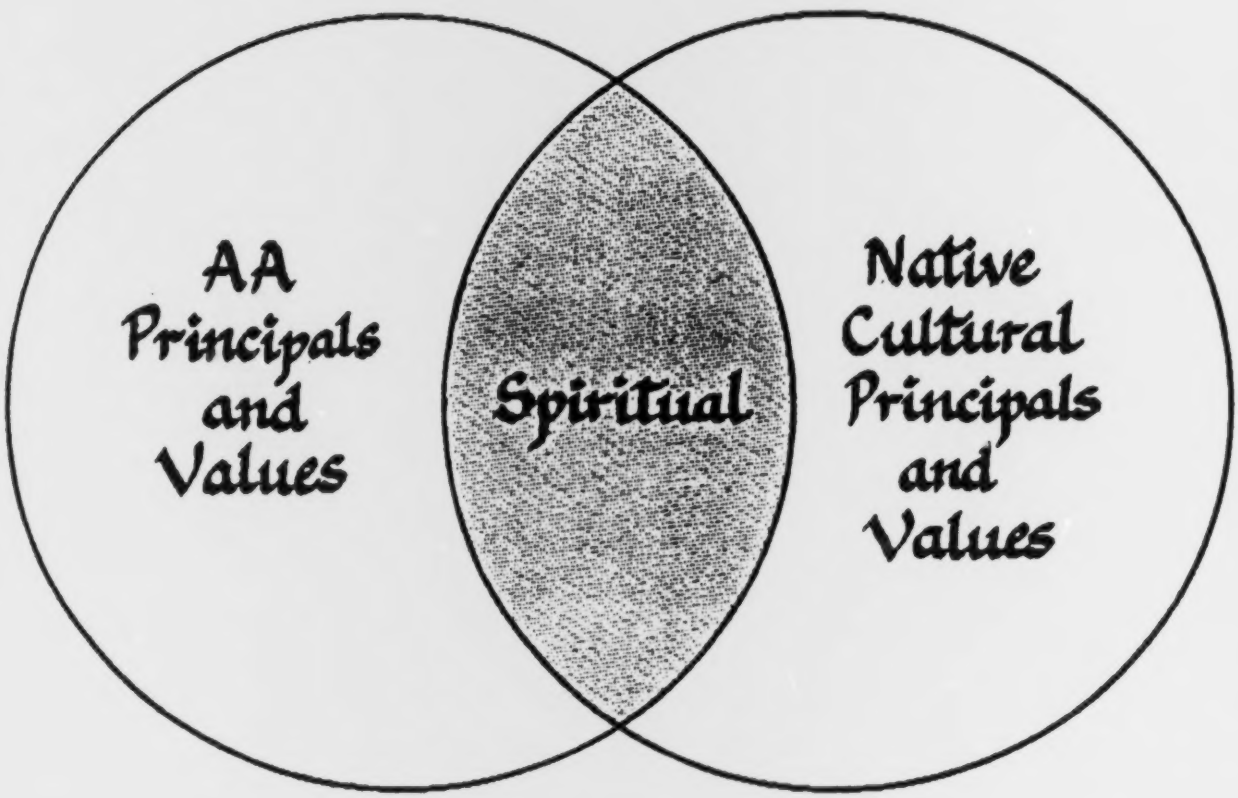
Both concepts are spiritual



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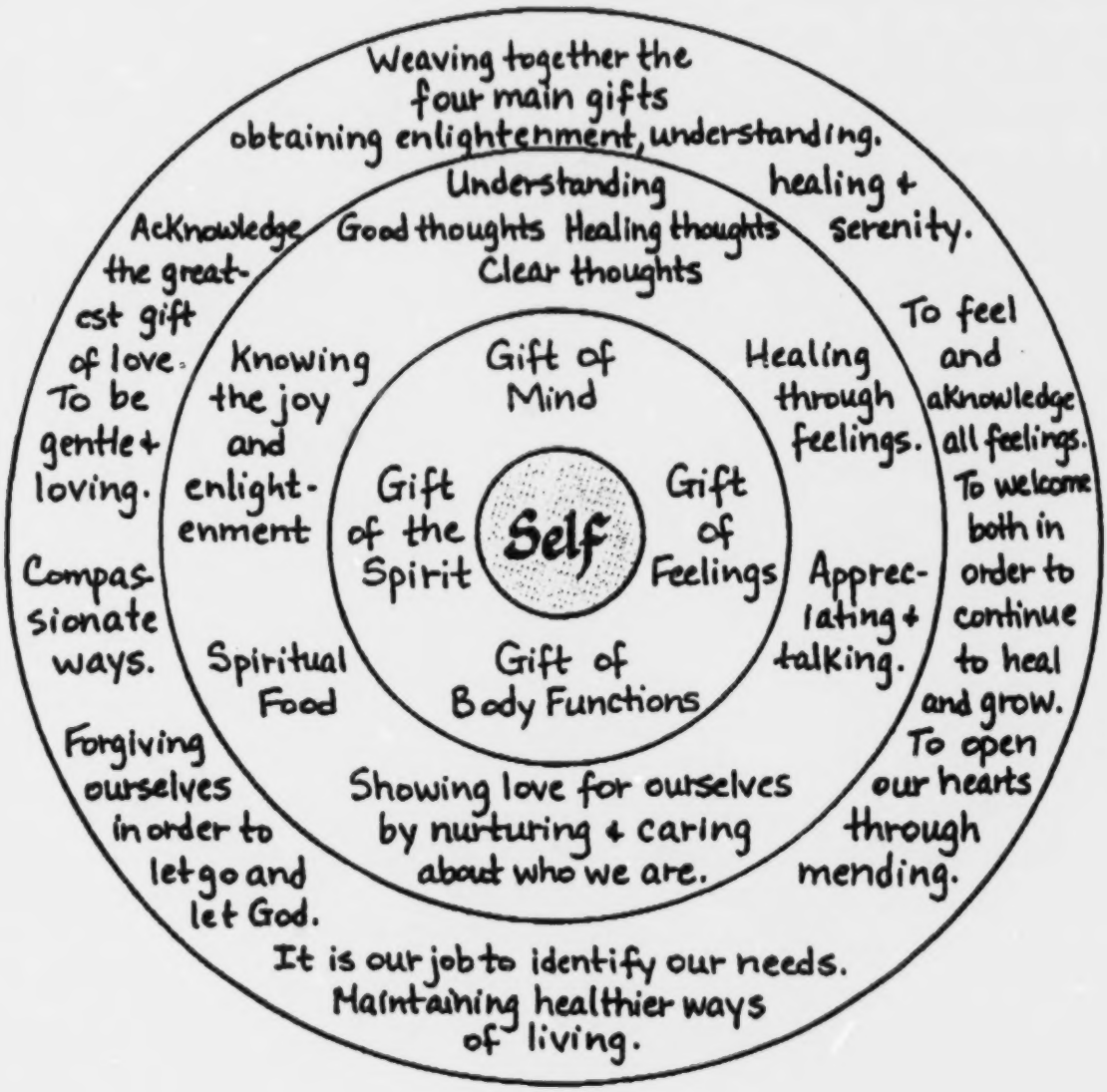
Beginning to heal and honor our Sacred Circle of Life


Weaving together the four main gifts obtaining enlightenment, understanding, healing & serenity.
Understanding
Good thoughts Healing thoughts Clear thoughts
AcKnowledge the greatest gift of love. To be gentle & loving.
Knowing the joy and enlightenment
Gift of Mind
Healing through feelings.
To feel and aKnowledge all feelings. To welcome both in order to continue to heal and grow.
Gift of the Spirit
Self
Gift of Feelings
Compassionate ways.
Spiritual Food
Gift of Body Functions
Appreciating & talking.
Forgiving ourselves in order to let go and let God.
Showing love for ourselves by nurturing & caring about who we are.
To open our hearts through mending.
It is our job to identify our needs. Maintaining healthier ways of living.

This process will help us to see, feel, think and allow the great mystery to work through us.

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Healing our Circle of Life

Do the homework of Self. Tap into four concepts of Self.

Goal:
Restructure and change ways.
Acknowledge the gifts we have to work with is honoring the Creator.

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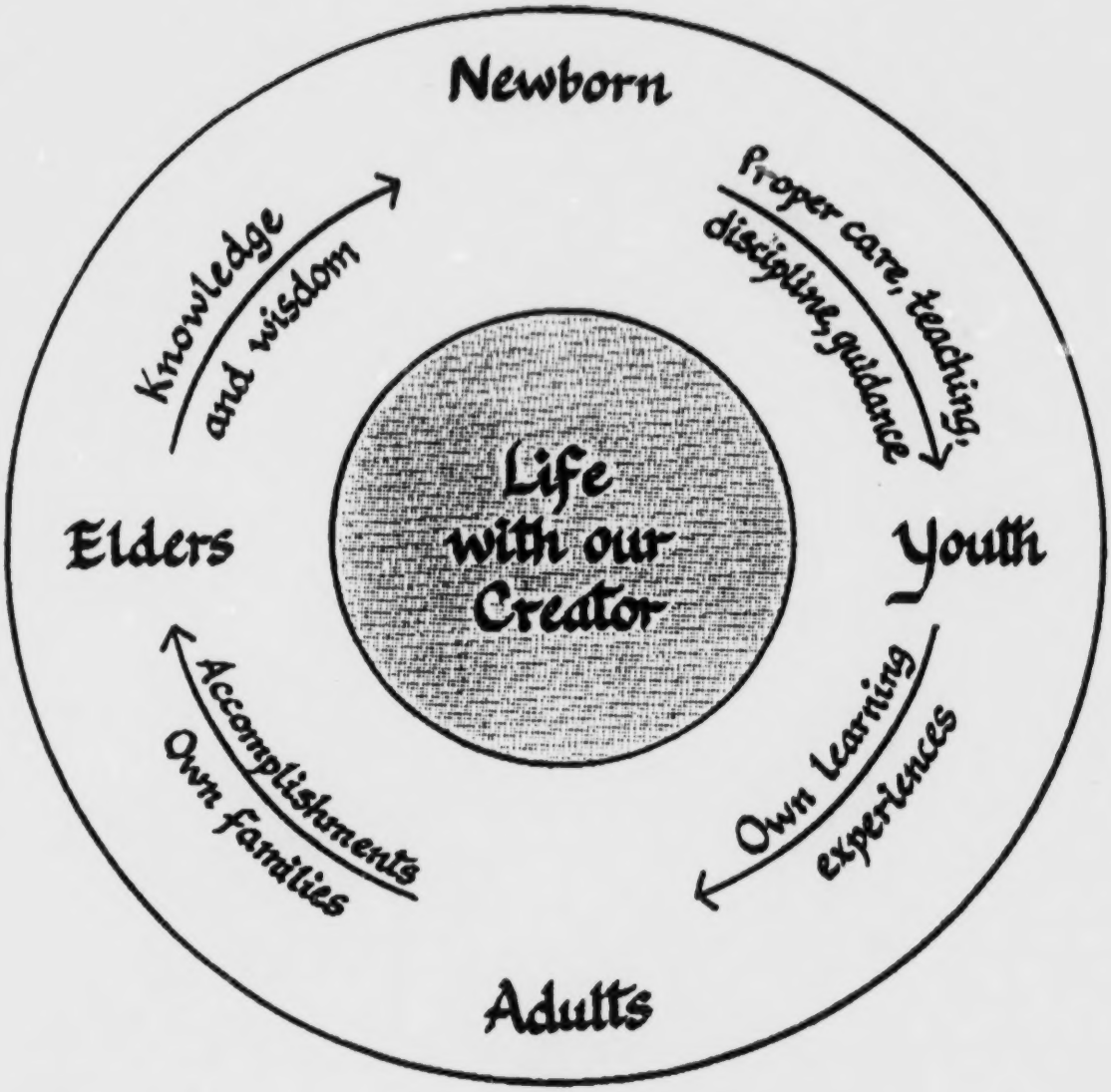
The Sacred Circle of Life



Goal:
To live a positive, creative life.
To live a life of fulfillment and challenge.
To reflect on life and honor the Sacred Circle.

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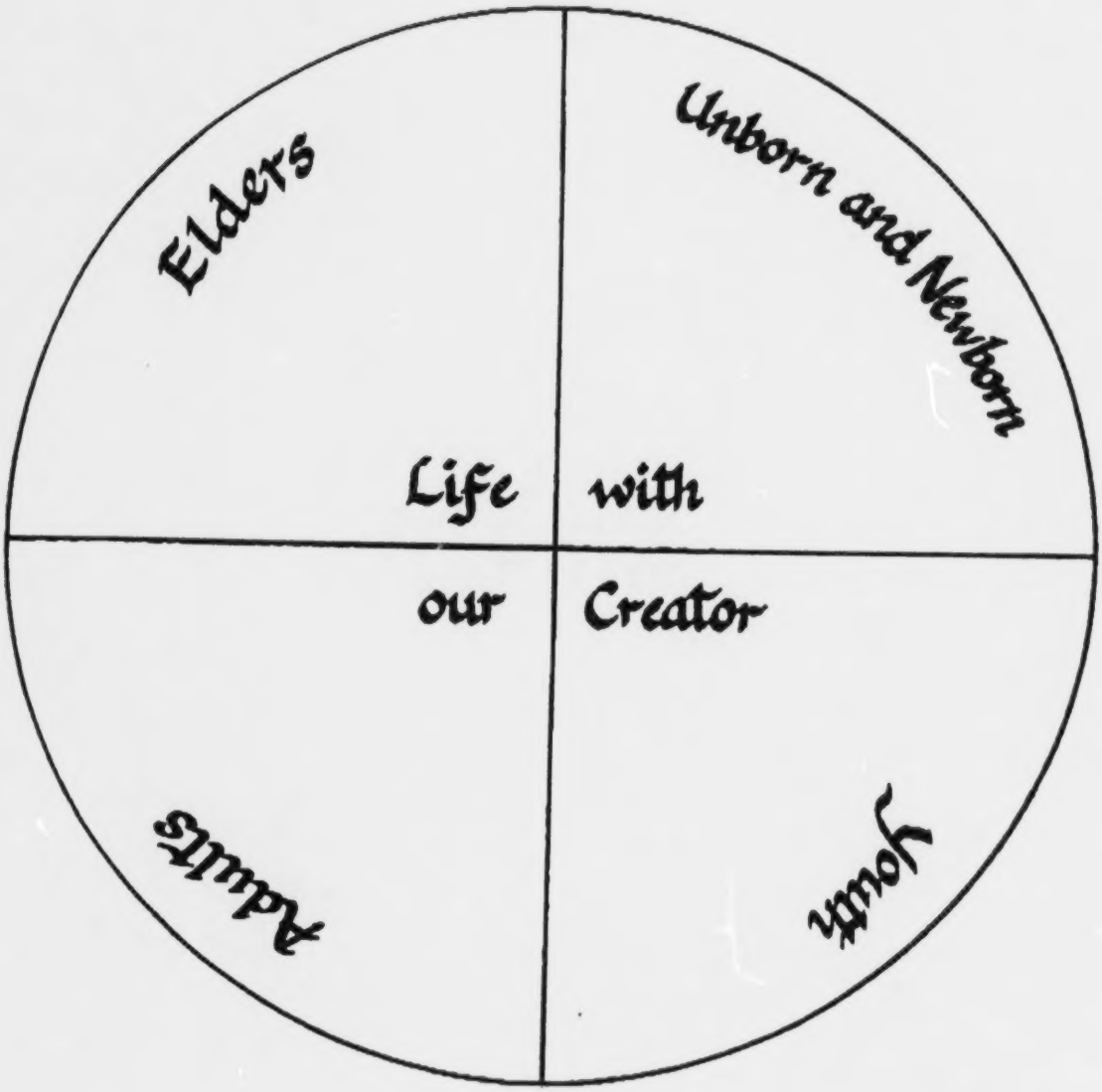
Circles of Life



by Georgia Fox

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COMMUNICATION TECHNIQUES & STRATEGIES: AMERICAN INDIAN CHILDREN AT RISK FOR INHALANT ABUSE/CHEMICAL ABUSE

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COMMUNICATION TECHNIQUES & STRATEGIES: AMERICAN INDIAN CHILDREN AT RISK FOR INHALANT ABUSE/CHEMICAL ABUSE

Mark Groves
Linda Welch

We've experienced a major change in the use of and the attitude towards alcohol and drugs in the past 30 years. School personnel, health-care providers, police, parents, etc. have become increasingly concerned about young people's use of mood-altering chemicals. As part of the process of growing up, it is common for young people to experiment with mood-altering chemicals. This tendency becomes apparent when we study the findings on the drug use and related attitudes of America's high school students. Recent epidemiological research leaves no doubt that the onset of alcohol and other drug use for most populations is between the ages of 12 to 20 with the peak age of initiation being 15 [1]. At the same time, however, in some inner-city environments and some special populations, e.g.: American Indian and especially among dropouts (who are not included in most studies), the onset of mood-altering chemical use by youth is occurring as early as five or six years old. [2,3,4] Because the use of alcohol and other drugs is often long-lasting, many young people carry problems resulting from abuse of mood-altering chemicals from the homes of their parents to their own homes and families and from their schools to their places of work.

According to the U.S. Indian Health Service, substance abuse is the most urgent health problem facing American Indians.[5] Inhalants are one of the first mood-altering substances used by Indian youth. Although most Indian youth do not get involved with inhalants and prevalence rates vary among Indian communities, Indian youth generally have much higher rates of inhalant use than non-Indian youth. Studies show that approximately one-fourth of the Indian youth who experiment with inhalants continue to use them.[6] Inhalant abuse appears to be an indicator of stress when social integration from the family has weakened and the peer group becomes a powerful force.

Solvents-inhalants produce effects much like drugs do, but solvents are not drugs (with the exception of the anesthetics and volatile nitrites). Technically, drugs can be defined as chemical substances that affect the functions of living things and are used in treating, preventing and diagnosing disease. In the popular sense, the term drug refers mainly to substances that affect psychological or behavioral functions or lead to varying degrees of dependence or addiction. For the most part, solvents were never meant to be ingested by humans and the manufacturers of solvents don't consider their products to be drugs and never intended for them to be utilized in any manner associated with drug use/abuse. The consequences of solvent abuse can and do cause serious neurological and physical damage to the abuser.[7]

As the United States is becoming increasingly aware of the seriousness of drug problems through its "War On Drugs" efforts, we must not overlook the use and abuse of solvents-inhalants by our very young. Inhalants do not have the glamour associated with them as does crack or ice, as such they are easily overlooked or ignored by most people. Most studies on solvent-inhalant abuse find that treatment is difficult because most treatment centers apply alcoholism/drug treatment techniques with the assumption that all chemically dependent people are alike. It appears that "sniffers" have less reasoning and resistance power than alcohol or other drug abusers due to interruptions in their thought process.[8] Generally, sniffers are not ready for therapy as we now apply it in the typical setting for up to 30 days, due to the longer detoxification period. The lack of effectiveness in the long-term treatment is not only due to lack of social and family support but also because they are stated too early on treatment programs. What are the inhalants? Why are they attractive to pre-teens? How do they learn about them? What are the psychological and physical consequences resulting from their abuse? Are solvent abusers different from other drug abusers? How do they respond to intervention/treatment? What can I do differently? What are some techniques I can utilize to effectively address/respond to the inhalant abuser and his or her family? This paper examines issues related to inhalant abuse, clinical features, characteristics of users and possible intervention techniques I order to

assist helping professionals and educators so that they can gain an understanding of the problem and become more effective in addressing and dealing with the inhalant abuser.

THE ORGANIC SOLVENTS

Inhalants are substances that are sniffed or huffed in order to produce mood-altering effects. Most inhalants are part of a large, but not very well-known group of chemicals called: volatile organic solvents. Volatility is a measure of the solvent's tendency to vaporize or leave the liquid state and enter the gaseous state. If you have ever smelled gasoline while filling your tank, smelled the glue you've used to repair something, or smelled the paint you've used in a closed-up room, then you are already familiar with the inhalants. The most common volatile organic solvents are the aliphatic and aromatic hydrocarbons which have only carbon and hydrogen atoms and are widely distributed in nature, primarily in natural gas, petroleum, and coal. Hydrocarbons are used for such things as fuels, propellants, to dissolve oils, paints, varnishes et.al., and they provide the raw material for such diverse products as synthetic fibers, polyvinyl, plastics, drugs, alcohols and thousands of other items. Any of the hydrocarbon solvents are potentially abusable but the most frequently employed are: toluene, acetone, methyl and ethyl ketone, benzene xylene, trichloromethane, trichlorethylene, the freons, and the volatile nitrites. Solvents are ubiquitously available in a variety of products such as gasoline, adhesives, paints and paint thinners, nail polish/remover, cleaning and lighter fluids, typewriter correction fluid, brake and transmission fluids, refrigerant gases, liquid waxes and removers, hairsprays, markers, aerosols, etc. They are available in every household, school, and store thereby making them the most accessible intoxicants to juveniles.[9]

Pharmacology

Organic solvents are central nervous system depressants that provide an initial short-lived excitant effect on inhalation.[10] The absorption of inhaled solvent is rapid across the large surface area of the alveoli (air cells in the lungs) into the blood so that the immediate effect of the inhalant is like an intravenous injection of drugs. Organic solvents are highly lipophilic, or chemically attracted to fats which means that they are most soluble in fats that in water and will therefore readily leave the blood and accumulate in fatty tissue such as those of the brain, heart, liver and muscles. The central and peripheral nervous system, liver, kidneys, lungs and heart have a high content of solvent after a single inhalation. The passage from these fat tissues of deposits back to the blood stream is characteristically low. Traces of hydrocarbons have been found in brain tissue in patients ten days after the last inhalation.[11]

During solvent inhalation, the chemical readily passes from the lungs into the blood, which then carries it directly to the brain. When a drug is swallowed or injected, it must first pass through the liver, which detoxifies or metabolizes the substance by breaking it up into inactive compounds. Because an inhaled substance moves directly to the brain and is therefore neither diluted nor metabolized, the effects are stronger than those produced by injected or swallowed substances. Because solvents were intended to dissolve, the effects can be quite severe. Once the solvent is in the body, it is primarily eliminated through exhalation.

When solvents are inhaled, the amount of solvent circulating with the blood produces several distinct stages of anesthesia. The first stage is analgesia, an absence of the sense of pain; the second stage is mental or physical excitement; and the third stage, called the surgical stage, is a complete loss of consciousness which is accompanied by muscle relaxation.[12] If the concentration of solvent in the blood becomes too excessive, respiration and circulation may become depressed or stop entirely as the solvent affects specific brain centers. Solvents interfere with the transmission of nerve impulses and alter electric activity in the brain. Because the exact mechanism by which anesthetics (solvents) affect the activity of the central nervous system has not been established with certainty by scientists or the medical profession, solvent abusers place themselves at greater risk for serious damage to themselves as they readily exceed safe levels of concentration. For example, the maximum allowable concentration of toluene (a common solvent-inhalant in paint) for industrial operations has been set at 100-200 parts-per-million. The concentration of toluene achieved during deliberate inhalation from a bag containing toluene-based paint or glue has been estimated by the Illinois Bureau of Toxicology to be 50-100 times this allowable concentration.[13]

Toxicology

Solvents-inhalants do not produce any on specific effect. Inhalant abuse subsumes a variety of different solvents and volatile mixtures comprised of a variety of substances of different proportions. It is important to recognize that volatile solvents are often combined to produce the most desirable properties of mixtures to achieve their industrial or commercial purpose. Most solvents can be classified as belonging to the sedative or anesthetic class of substances.[14] Toxicities range from relatively nontoxic to carcinogenic in nature. Most of the literature dealing with solvents is derived from studies of single agent exposure aimed at providing safety data and hazard evaluation from the work environment. Because solvents were never intended for human consumption, their acute and chronic toxic effects on sniffers are essentially unstudied.

Short-term symptoms of use may include: euphoria, excitation, dizziness, hallucinations, coughing, nausea and vomiting, flushed skin, bizarre behavior, confusion, disorientation, ringing or buzzing in the head, blurred or double vision, headache, drowsiness, slurred speech, nystagmus, depressed reflexes, unconsciousness, seizures and EEG changes.

Long-term consequences may include: central nervous system damage which reduces physical and mental capabilities; respiratory damage; heart, liver, kidney and bone marrow damage; coma; and death.

Sudden Sniffing Death

Solvent abuse carries with it the risk of death. Severe cardiac arrhythmia is the most likely explanation of sudden death while sniffing solvents, with stress or activity or over-breathing as exacerbating factors.[15] Many solvents cause ventricular fibrillation which is an abnormal pumping action of the heart. The heart becomes sensitized to norepinephrine which is a substance produced in the adrenal glands that is normally released during stressful situations. This combination of inhalants use and stress overstimulates the heart. Solvents can also depress the ability of the heart muscle to contract, which can result in the heart and body being undersupplied with the usual amount of blood. There have been at least twelve cases of sudden sniffing death in Minnesota within the past five years.

Due to the known pulmonary impairment and cardiotoxicity produces by the solvent, the possibility of cardiopulmonary dysfunction should be suspected. It is important not to confront or aggravate the solvent abuser because they may become quite irritable, restless or violent. It is recommended that they be kept in a calm, warm, reassuring atmosphere. The "sniffer" should be monitored for any appearance of cardiac or respiratory abnormality.[16]

Why Solvents Are Abused

It is usually difficult for non-consumer of solvents to understand why any of the solvents would be deliberately inhaled for purposes of intoxication. Industrial workers usually take extra care and caution when working with solvents while young people wittingly inhale concentrations 50-100 times greater than the maximum allowable concentration in industry. The reasons for sniffing's popularity are:

Peer group influences: This appears to be the strongest factor in the initiating and perpetuation of the use of solvents. This group not only dictates whether solvents or aerosols are to be abused, but even which brands and how to use them. If the crowd one goes around with are all sniffers, it is very difficult for an individual group member to abstain.[17]

Developmentally, adolescents derive progressively less protection and information from their parents, while at the same time receiving increasing support and choosing more interaction with peers. It is important to remember that youth are not influenced equally by peers in all areas of life. Teenagers most strongly influence each other regarding dress and appearance, choice of leisure-time activities, language, and the use of mood-altering chemicals. Parental influence is strongest with regard to moral and social values, vocational choice, and educational plans. Some youth are more parent-oriented while others are more peer-oriented and these choices with respect to chemical use may differ according to those orientations.[18] Studies suggest that youth are more at-risk if the group is comprised of nonusers. Peer-oriented youth are more at-risk if the group is comprised of nonusers. Peer-oriented youth are more at-risk if

their friends use substances; parent-oriented youth are more at-risk if their parents are users.[19] Future drug users exist in an environment characterized by "significant others" who tolerate or encourage drug use and by readily available drugs. Adolescents who spend most of their free time with peers are more likely to experience such an environment than those who spend their free time with their family or alone.

Cost: An important factor in determining whether to use an inhalant is cost. Many sniffers are from low-income families and price is a decisive factor for them. A can of spray paint is cheaper than liquor or marijuana.

Availability: It usually takes some planning for juveniles to obtain alcohol or drugs, whereas gasoline, paints, aerosols, etc. are available in every household, school, and store.

Convenient packaging: Many products such as typewriter correction fluid, markers, nail polish, tubes of glue, etc. are small and can be concealed in one's pocket more successfully than a pint of liquor or a six-pack of beer. The compact packaging is especially convenient for those still in school to sniff either during or between classes. Their small size also makes shoplifting easy.

Mood elevation: Most inhalant users say that sniffing makes them feel good; they like the "high"; and, it makes them unafraid. They feel euphoric, giddy, and it blots out unpleasant elements of their everyday lives. They report that they enjoy the hallucinations that commonly occur.

The course of intoxication: It is often rated better than alcohol or other drugs and it is a quicker "high". Users can also more easily control the level and length of the "high" and can become sober after about one hour. The solvent hangover is less unpleasant than that which occurs from overuse of alcohol; however, headache and nausea are the two most common complaints noted during recovery from overuse.

Legality: Being in possession of some spray paint or other solvent by youth is not illegal, whereas the possession of marijuana or alcohol is. It is also easier for the sniffer to explain to his parents why he smells of chemicals than it is if he smells of liquor: "I was helping Johnny paint his bike."

EPIDEMIOLOGY OF SOLVENT ABUSE

Incidence and Prevalence

Inhalant abuse, particularly by the young, has been a health problem throughout the world since the 1950's.[20,21,22] The prevalence of solvent abuse varies greatly from population to population and from time to time. The High School Senior Survey conducted by the University of Michigan's Institute for Social Research every year shows that approximately 17% - 20% of U.S. seniors have tried inhalants at least once between the years 1975-1989.[23] In 1982, nearly two-thirds of those surveyed reported at least one experiment with drugs. In 1988, the survey showed that more than half (54 percent) of the seniors had used an illicit drug at least once. The use of illegal drugs by young adults has been declining over the past 15 years with the exception of the inhalants and hallucinogens, which have both increased by small amounts. Inhalant use by American Indian youth is twice the U.S. average for all children between the ages 12-17. The following graph illustrates the prevalence and recency of drug use of the class of 1987. (See Appendix A.)

The semiannual report of Drug Abuse Indicators in the Minneapolis/St.Paul area shows that there have been increasing reports of, and public concern about, the use of inhalants by inner-city children, particularly within the American Indian community.[24] Between January 1987 and September 1988 there were 58 admissions to the Minneapolis Area Adolescent Detox Center in which the primary intoxicating substance was an inhalant. The average age of those admitted was 12.7 years old. Forty-eight of the fifty-eight total inhalant episodes (82.8 percent) involved American Indian youth. During this same period, there was a total of 500 American Indian youth admissions to the Detox Center. Of this number, fifteen percent (77) acknowledged using inhalants during the past 12 months prior to their admission to detox.

The Drug Abuse and Alcohol Normative Evaluation System (DAANES), a data collection tool designed by the State of Minnesota, Chemical Dependency Program Division used to collect drug use history information from state and county organizations, reveals that adolescents admitted into treatment who identified inhalant abuse as a primary problem had increased fifty-seven percent from 1987 to 1988.[25] Overall, between the years 1985-1989,

twenty-five percent of adolescents admitted to treatment within Minnesota reported to the use of inhalants within six months of their admission. Twenty percent sniff 1-2 times per month, eleven percent sniff weekly and, eleven percent sniff daily. As a class of chemicals used within Minnesota, inhalants ranked sixth among adolescents admitted to treatment in 1988-89 behind alcohol, marijuana, hallucinogens, amphetamines and cocaine.

Among adults admitted to treatment, inhalants are the least abused chemical substance.[26] In both 1988 and 1989, two percent of the adults admitted had used inhalants in the last six months. Seven percent of the adult admissions under age 21 years had used inhalants prior to admission. Among adults, American Indians were most likely to have used inhalants. Five percent of the American Indians, three percent of the Hispanics, and one percent each of the Whites and Blacks had used inhalants prior to admission.

The Minnesota Department of Education conducted a Minnesota Student Survey during the Spring of 1989.[27] The survey was administered to 91,175 students in grades 6, 9, and 12 from 390 of Minnesota's 433 school districts. Two percent of the sixth graders, four percent of the ninth graders and two percent of the twelfth graders reported to the use of inhalants within the past year. Alcohol is the most widely-used substance among Minnesota students followed by tobacco, marijuana, amphetamines, prescription drugs, and inhalants. The following graph illustrates the recency of drug use in 1989. (See Appendix B.)

The total number of sixth graders who responded to the Minnesota Student Survey was 31,037. The ages of these children were primarily 11 and 12 years old. Sixth graders who report having abused inhalants suffer disproportionately from a considerable array of problems. These problems are generally related to their families, where communication is usually poor. Half of these sixth grade children have had suicidal thoughts or have attempted suicide, as compared to twenty percent of non-sniffers. The following table differentiates sixth graders who report use of inhalants from sixth graders who do not. (See Appendix C.)

The 1988 Minnesota State Legislature mandated a two year Inhalant Abuse Demonstration Project for inhalant abusers between the ages of 7-14. One of the project objectives was to provide assessment services to sixty children and their families by July 1991. The Community University Health Care Center (CUHCC) administered this project for a two-year period preceding June 1991. During the first nine months of the project, 15 children participated in the project; even though this project was open to all children, all 15 children were America Indian. The children enrolled in the project receive neuropsychological screening. The assessment battery includes tests of general intellignece, memory functioning, visual-motor integration, academic achievement, verbal fluency, and concentration. A preliminary summary of test data indicates that only one of the 13 children tested appeared to be progressing normally with respect to intellectual neurological, and academic skills development. Five of the thirteen children (38 percent) display striking evidence of neurological dysfunction affecting their ability to engage successfully in basic academic tasks. Available evidence suggest that these neurological deficits preceded any exposure to inhalants. An additional six children (46 percent) demonstrated marked intellectual inefficiency that could not clearly be attributed to neurological dysfunction. Depression and other substantial emotional adjustment problems were believe the most likely explanations for this failure to process and integrate information efficiently. Overall, the data suggest that the vast majority of children enrolled in this project were at high risk, either neurologically or psychiatrically, prior to any significant inhalant involvement. The project staff hypothesize that the children likely turned to experimentation with inhalants as a way to cope with pre-existing feelings of failure or inadequacy. Many of the children appear significantly clinically depressed or demonstrate other emotional and behavioral maladjustments related to growing up in markedly unstable or chemically dependent homes.

INTERVENTION/TREATMENT

Based on available studies on the treatment of solvent abusers, most clients do not respond well to the programs. Most of these youth are not motivated to participate in the treatment process, may be mentally slow, have low self-esteem, are immature, and generally do no respond well to formalized therapy or treatment approaches. Group therapy and confrontation typically do not work very well, whereas individual sessions with specific counselors who get along well with these youth and

families demonstrate more success. The clinical setting must be warm, open, and non-threatening.

In our work with young solvent abusers and their families, we have gained new insights into how to view the child and refreshing approaches that are promising. We must go beyond the presenting problem and instead focus on the health and well-being that is inherent or innate in all of us. Mental health and well-being is a natural, inborn basic state of mind whose characteristics are simplicity, balance, security, and feelings of love for self and others. Many people refer to this state or feeling as being spiritual; the chemical dependency profession calls it serenity. As mental-health professionals, our goal is to guide our clients to their own spiritual, serene, or positive states of mental health.

Children, for the most part, live in this natural state of well-being. They do so without thinking about it or having to be told or taught about it: it is as natural as breathing. Usually, we do not need to teach children how to experience or express happy feelings because that emotion is inborn. What usually happens is that as children grow up they learn how to express themselves by modeling peers and adults in their lives. This learned behavior then becomes very powerful and is difficult to change. Those children living in chaotic or dysfunctional family settings learn certain negative behaviors. If the parent lives with insecurity, then that is what the child learns. On the other hand, if the parent lives in more worthwhile states, then the child will learn this.

In our work with very young solvent abusers, we are discovering that these children learn about the use of various substances that will alter their mood at very early ages. We have also realized that most of the pre-teen solvent abusers are moderately "street-wise" and sophisticated as adolescents in their middle and late teens. For those children who reside in homes where the dynamics of chemical dependency are present, we have observed their insecurities take such forms as unhappiness, depression, and failure to thrive. As a counselor, you are faced with an array of issues and how to help these young children and their families. More importantly, how do you promote change within the client and keep him or her coming back for more?

We have learned that focusing on or reviewing the multitude of problems with the client is counter-productive. The child and family are already aware of this shopping list and they do not require reminders. Not focusing on the problems has led the client (and us) to greater levels of understanding and enjoyment. For, what better result is there than when the client leaves your session feeling better and looking forward to the next appointment? A question to ask yourself is: "What is it that this person is truly seeking?" If they are using a mood-altering chemical to feel better, then you need to help them discover something superior that will replace that chemically-induced "high" feeling. Focusing on outside solutions haven't worked, so we began focusing on solutions that resided within the client. We know that each child has self-esteem, positive feelings, intelligence, wisdom, and good judgement and that these characteristics remain the potential for mental and physical health. What clouds these characteristics is a negative learning process and self-limiting and self-defeating ways of thinking. We know that people learn insecurities via verbal and non-verbal messages. When this occurs, thought and behavior become dysfunctional and change difficult to attain.

In talking with these children, allow your common sense and positive feelings to be your guides. We do not talk with the children as though we are information gathering, conducting therapy of having a counseling session, instead, we keep it fun and simple. We talk with them just as we do with our friends. We tell stories, share a joke, show concern and love and let them know that they are important. We have gained more information from a child enjoying cookies and milk than filling out forms in front of the child. Children are very intuitive and can readily ascertain by your mood and actions whether or not you are going to be someone they can trust. Children possess the uncanny ability to read people; this is especially true for the young solvent abusers. Their instincts are sharper and they can readily appraise adults, helping them to get along in their environment and survive. If they do not trust you, they will definitely let you know via verbal or non-verbal means. When this occurs, it is important for us not to take this affront personally.

In working with families, the best and often easiest approach is via the child. Rather than focusing on the problem at hand and exploring what the parent has done in the past (which usually causes the parent to become defensive), focus on the health and well-being of each individual. Avoid labeling. Rather than having the attitude of seeing a "sniffer", and alcoholic or some other classification, we found

it easier to consider the person as a human being with the potential for mental health and well-being. In order to help the young solvent abuser, your relationship with the parents or guardians of that child are paramount. Trust and rapport need to be established within the first meeting. Typically, many of these families have a long history with the social services systems and, thus, are apprehensive and distrustful of "helpers". We had more success with families when we took off our counselor hats and just behaved naturally. Keep the conversation simple and talk about light and airy subjects. Once the parents feel at ease and relaxed, they will then be able to develop trust in you and thus open up to you about their issues and problems. More importantly, when the parents feel at ease, they will be more open to listening and exploring solutions. As you know, the key to any good counseling session is when everyone leaves feeling good/better.

Despite the chaos that the parent may be experiencing in their lives they care about and love their children. If parents sense that their children are in danger in any manner, they will typically respond in kind. We found that parents are willing to respond to such concerns as the child's educational experience regarding the child's learning, attendance, grades, classroom behavior and peer influences. As you begin discussing and working on these issues, the parents will feel a sense of accomplishment and alliance with you and then they may begin to discuss not only their own issues with you but also their own sense of helplessness and hopelessness.

CONCLUSIONS

Inhalants encompass a wide range of substances which have a wide range of potentially toxic effects on the user/abuser. Most solvents were never meant for human consumption and they are ubiquitously available in every household. It appears that solvent abuse is significant and requires our serious attention. Solvent inhalers are likely to have more emotional and behavioral problems that do non-drug users or other types of drug users. The consequences of solvent abuse early in life may lead to markedly dysfunctional adulthood because of neurological and learning deficits developed during maturation. American Indians show higher levels of inhalant abuse than those found among other American youth. They often tend to start using mood-altering chemicals earlier than other youth. Because of the nature of solvent abuse and it's associated dangers, it is apparent that prevention and interventions must take precedence over treatment. Rather than approaching the solvent abusers and their families from a "professional helper" stance, we must be innovative and gain the trust and rapport from them in order to bring them back to mental health and well-being. As social service and mental health providers, we need to address these vital issues on a very simple and basic level. It is imperative that the family become involved in the therapeutic process. Prevention and intervention must start very early. Family, school, and community must work together to solve this very perplexing problem.

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APPENDIX "A"

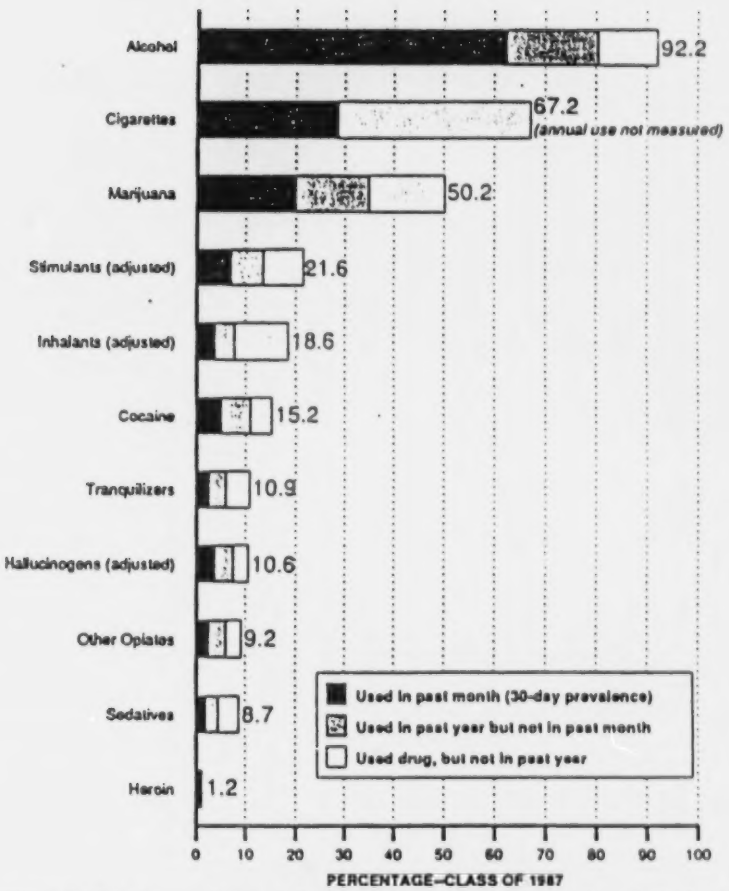

Figure 3. *Prevalency and recency: Percent of 1987 U.S. high school seniors who had used a drug in their lifetimes, in the past year, or in the past month, by drug type.*

Source: Johnson et al.

APPENDIX "B"

TABLE 13

USE IN THE PAST YEAR

	6th Grade %	9th Grade %	12th Grade %
Alcohol	8	47	76
Tobacco	6	28	41
Marijuana	*	9	18
Speed or amphetamines	*	5	6
Cocaine (powder or crack)	*	2	3
Inhalants (glue, paint, etc.)	2	4	2
Sedatives	*	2	1
Other illegal drugs	*	3	3
Other people's prescription drugs	2	4	3
Steroids	*	1	1

* Less than 1%

1989 by the Minnesota Department of Education, St. Paul, Minnesota

APPENDIX "C"

	Boys		Girls	
	Nonusers	Users	Nonusers	Users
Truant during past month	17%	30%	12%	22%
Poor grades in school	10%	30%	5%	9%
Doesn't believe family cares	15%	44%	16%	39%
Doesn't believe others care	17%	52%	13%	30%
Low self-esteem	9%	17%	13%	30%
Emotional distress	9%	30%	11%	26%
Shoplifting, fights	18%	57%	8%	44%
Gets a kick out of danger	32%	65%	14%	44%
Suicidal thoughts or attempts	20%	48%	19%	52%
Has had professional treatment	13%	41%	10%	4%
Parents abuse chemicals	11%	13%	11%	22%
Beaten by adult in household	12%	22%	11%	27%
Witnessed family violence	13%	22%	13%	27%
Believes adults exaggerate drug dangers	26%	53%	21%	39%
Can talk to father about problems	52%	22%	30%	9%
Can talk to mother about problems	61%	21%	63%	35%

BEST COPY AVAILABLE

COMMUNITY CHILD REARING: BACK TO BASICS IN PREVENTING SEXUAL ABUSE

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COMMUNITY CHILD REARING: BACK TO BASICS IN PREVENTING SEXUAL ABUSE

Trudy Multine
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PROGRAM DESCRIPTION

This child sexual abuse prevention curriculum for Native American Head Start Programs and Preschools will be available for distribution by January 1st, 1992.

The program is currently being tested by the Lummi Head Start Program on the Lummi Reservation in Washington State. Several experts are guiding its development. A parent committee is facilitating the development of the parent portion which will feature parent support and involvement.

CURRICULUM GOAL

The goal of the Northwest Indian Child Welfare Association's curriculum is to reduce child sexual abuse in Native American communities.

ORGANIZATION AND IMPLEMENTATION

This curriculum is organized in three parts. The Administration section describes how to implement the program. It discusses advocacy issues, the director's administrative responsibilities, the coordination and policy development responsibilities of the Head Start Parent Policy Council and the classroom role of the teacher as well as reporting and training requirements for all the staff.

ADULT CURRICULUM

The Parents As Partners section discusses parent participation in teaching Head Start children personal safety skills. The curriculum addresses issues associated with early childhood development and Native American child-rearing practices.

Parents are encouraged to help teach prevention by reinforcing the personal safety lessons through "take homes" which the teacher sends home each time a new lesson is introduced. This portion of the curriculum includes a parent video to be used by the director in parent/community orientation sessions throughout the year.

CHILDREN CURRICULUM

This section contains instructions for teachers and nine-month personal safety lesson plan based on the assumption that children can be taught prevention skills if they are empowered with self-confidence. It further assumes that adults in a child's preschool environment want to empower the child with self-esteem.

Lesson objectives are based on developing personal responsibility, communication, non-violence, assertiveness and problem-solving skills which are critical underlying concepts that children need to understand in order to protect themselves. Children learn they have their own personal space which includes the air all around their bodies, they learn to name their body parts, including their genitalia, to say no to unwanted touch and who to go to for help. With role play they learn self-protection skills associated with risky situations.

A CRITICAL LOOK AT NON-NATIVE AMERICA CHILD PROTECTIVE SERVICE AGENCIES - WHO ARE THEY REALLY SERVING?

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A CRITICAL LOOK AT NON-NATIVE AMERICAN CHILD PROTECTIVE SERVICE AGENCIES -- WHO ARE THEY REALLY SERVING?

Ricardo Jasso
Ralph Varela

This presentation will focus on examining the prejudices and biases of non-Native American child protective service workers toward Native American service recipients. The presentation will focus on how historical racism cognitively impacts service delivery to non-reservation Native Americans and how these attitudes and behaviors have a detrimental impact on family wellness and survival.

From a historical viewpoint, issues of encroachment, displacement, and denial of basic fundamental rights are based on ignorance, prejudice, and racism. From a social service perspective, the above are translated into overt and covert negative delivery of needed social services. In cases of child abuse, these covert and overt actions may include the following: 1) Unreal or unobtainable goals. 2) Jamming services. 3) Not providing services. 4) Exclusion of extended family. 5) Removing children without cause. 6) Trangulizing family members. 7) Placing of children in non-Native American foster homes. 8) Refusal to recruit Native American families for foster care. 9) Assigning more cases to already burned out workers.

The following points of reference are important to note in assessing non-Native American child protective service workers: 1) Most CPS workers have never been on a reservation, have no understanding of life dynamics on a reservation, and know little about the richness of the culture. 2) Most CPS workers know very little about their own cultural background. 3) Most CPS workers have no appreciation of the concept of culture. Rather than confront their feelings of inadequacy and ignorance, they attempt to label and become simplistic in their assessments. 4) Without an understanding of norms, values, and patterns of communication, one becomes ethnocentric. Thus, they seek to control and possess the other culture, changing it to their level of comfort. The other culture becomes irrelevant in their approach to human interaction. 5) "Dances With Wolves" Syndrome - a non-Native American CPS worker sees a movie, buys jewelry, eats frybread, decorates their home with Native American artifacts and sincerely believes that they are culturally sensitive. Often, when a service recipient "doesn't respond", the provider becomes immediately frustrated, doesn't invest in the case, and blames the victim. Often, the most liberal non-Native American social service providers are the most racist.

In relation to child abuse, it is imperative that issues of discipline be viewed within a cultural framework. There is a tendency on the part of CPS workers to believe that the United States possesses the correct recipe for effective discipline and, yet, American youth are in crisis.

There basically is no difference between how white settlers encroached and then displaced and how child protective workers are attempting to encroach and then displace Native American families.

There are many issues that impact the quality of care provided by non-Native American child care workers. The following are but some of those that need to be addressed, but by no means include all of them: prejudices, biases, historical racism, reservation children, attitudes, behaviors, encroachment, displacement, child abuse, non-Native American child care workers, and lack of appreciation and understanding of Indian culture.

This presentation will introduce a structured group interview or focus groups to begin dealing with very sensitive subject areas. Focus groups are informal sessions in which non-Native American child care workers can be asked to discuss their thoughts on a specific topic, service, or product. Focus groups have been used in health research to explore certain attitudes, beliefs, and perceptions within the health industry towards minority health recipients.

The focus group interview is an alternative approach to more classic approached to address child care barriers affecting Native American children and families. These classic approaches, such as classroom instruction, have been totally ineffective and sometimes even toxic because issues of racism, discrimination, genocide, and social diseases are not processed in a meaningful manner. Classic approaches have three basic weaknesses: 1) They keep non-Native American child protective service

workers operating within a safety zone. 2) The setting does not allow or permit hidden biases and prejudices towards Native American customs, traditions, beliefs, and practices to be addressed. 3) They create a sterile environment of non-engagement which translates into a zero commitment for change.

The utilization of focus groups therefore, might serve as a viable alternative to train non-Native American child care workers in ways that would be more sensitive, responsive, and perceptive toward Native American children.

FAMILY VIOLENCE,
A COMMUNITY CONCERN

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FAMILY VIOLENCE, A COMMUNITY CONCERN

Christine Burd-Cobell

Family violence is a problem that affects the whole community. It robs individuals of their peace and security. It often results in physical and/or emotional injury and sometimes even death. Coping with the devastating effects are a drain on the entire reservation.

When I first came to the Blackfeet Reservation to work in 1986, I became more aware of family violence. There were approximately three to four patients a week coming into Behavioral Health, or the emergency room, for violence-related problems. The police department was getting thirty calls a week that they had to respond to regarding domestic abuse. The court had ten restraining orders filed, nine of which were usually dropped before the week was out. No one in the community was addressing the problem. The attitude was, we can't take care of the problem here on the reservation; we need to send the women victims to Great Falls and they (the victims) felt there was no protection for them. The offender was not getting charged with the crime and the family as a whole was not being treated.

Early in 1987, IHS identified the goal that needed to be achieved in order to raise the health status of Native Americans. Service units were assigned to do prevention planning. There were five areas that were recognized that the prevention planning would be directed toward: nutrition, fitness, accident prevention, substance abuse, family planning, and domestic abuse.

A committee was formed at the hospital and a Behavioral Health social worker was assigned to the family violence project.

The contributing factors of family abuse were:

1. Availability of safe environments
2. There is no tribal code addressing spouse abuse as a crime
3. Availability of treatment facilities
4. Lack of public awareness
5. Children view domestic violence as normal behavior

Contributing Factor Number I: The objective was that all women that are victims of domestic violence will be offered safe environments, safe homes, and hospital attention. The hospital would admit victims to the hospital if they were in need of medical care. If after hours, a social worker would be called and arrangements would be made for the patient to go to a safe home in Great Falls, Havre, which were the only available facilities at the time. If victims did not need emergency medical care during working hours, they were referred to Behavioral Health and then sent to Great Falls or an available safe home.

At that time there was no money available for transportation. Social workers would sometimes transport patients on their own time, if there were no family members to take them. Six hundred dollars was given to Behavioral Health from a movie that was produced on the reservation. The money was used to transport victims to a safe home. When this funding was used up, social workers continued to transport victims on their own time.

With the help of the community and continued efforts from the Behavioral Health social workers, a safe home was opened in the community on May 12th, 1990. It was funded by the State of Montana Crime Control. They had eighteen people go through the program as of June 13, 1990.

Contribution Factor Number II: "By the end of FY-87, there will be a section of the tribal code addressing spouse abuse as a crime."

Behavioral Health social worker, Christine Cobell researched tribal codes on other reservations. There were no tribal codes on reservations in Montana. The state had passed a domestic abuse law in 1985. The social worker rewrote the state law in order to address this lack in the tribal government. The only major change resulting was mandatory counseling for the offenders. She then presented the abuse law to the city council and Mayor Kennerly on July 1, 1987. At that time the city adopted the law into their codes. On July 2nd, Mayor Kennerly and Christine Cobell presented the law to the tribal counsel, at which time they adopted all the city ordinances, including the domestic abuse law. A week later, this domestic abuse law was rescinded.

The Behavioral Health social worker then formed a committee with Blackfeet tribal lawyer, Vicky Santana and BIA Special Officer, Glen Little Bird. They reviewed the law on July 23rd, and on August 6th. Christine Cobell went to the general counsel meeting and presented the domestic abuse law. The law was discussed and denied. The counsel stated that they would not pass the law because there had been no training for the police department. Christine Cobell then arranged with the CutBank Police Department to come to Browning and do a one-day training session with the police department. On September 2nd and 3rd, the social worker arranged for the Havre Domestic Abuse Program to come in and conduct a workshop on domestic abuse for the court and police department. Other agencies were also invited. On October 1st, Christine Cobell gathered a group of concerned people and alcohol program victims of domestic abuse, and then went to the tribal counsel meeting to present the law. After much discussion the tribe passed the law. It remains in effect to this day. This law was the first one on domestic abuse in the State of Montana.

Contributing Factor Number III: "By FY-88 the number of treatment programs and self-help groups will increase from 2 to 4."

To assess the current program, the social worker visited the Great Falls Mercy Home and talked with the Havre Domestic Abuse Program, and attended a workshop in South Dakota on family violence. Behavioral Health continued to do individual treatment for the families that were involved with abuse. In July 1989, a person from the alcohol program attended a workshop on domestic abuse sponsored by the Duluth Minnesota Treatment Program. In November 1989, a program for the batterers was started. Since the program started, the court has mandated that offenders go into this one-month program; approximately forty clients have been through the program and there is a waiting list. (This program is a success.)

Behavioral Health still offers individual counseling and conducts groups. The safe home, which recently opened, treats victims and their children, who are also treated at the safe home. There is a high incidence of domestic abuse and alcoholism, ninety percent of clients that experience family violence have a alcohol problem or have been raised in a alcohol environment. There are groups and 12-step programs available seven days a week in Browning and HeartButte. Social workers had implemented a 12-step program at Babb on Tuesday nights in 1987. This group still meets. The social worker started groups of ACOA and Co-Dependency which the families do attend.

Contributing Factor Number IV: "Lack of public awareness of the problem".

Objective Number IV: By the end of FY-90, fifty percent of the population over 15 years old will be aware of programs available to go to for assistance for domestic abuse.

Presentations were done at the school by the social worker twice monthly. Christine Cobell completed a television commercial for Channel 5 on domestic violence. (It aired for one month.) In addition, Ms. Cobell designed a pamphlet on domestic violence. Both the television commercial and pamphlet were funded by Tribal Health. Articles appeared in the Browning twice a month. In November 1989, a workshop for the community and agencies on domestic abuse was offered and on
May 15th, 16th, and 17th. Workshops on family violence for the community were held and were sponsored by the alcohol program and a committee was formed on the reservation to work with the agencies and communities on domestic violence, an on-going process.

Contributing Factor Number V: Children view domestic violence as normal behavior.

Objective Number V: To increase self-esteem of children ages 3-12 by ten percent; thereby, reducing acceptability of violence in the home, as assessed/reported by IHS, Law & Order. Behavioral Health did inservices for Head Start and continued to sponsor groups at the schools. Behavioral Health also does presentations at the college, high school, and grade schools.

HOME BASE

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HOME BASE

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BACKGROUND

Home Base is a family strengthening, preservation and reunification program within a domestic violence program at Pueblo of Laguna. The Home Base program in the form outlined in the discussion draft of March 26, 1990 was implemented by Laguna Family Services as a pilot project in June 1990. Between April and December 1990, twenty-three community services providers and tribal council members reviewed and commented on the discussion draft, to ensure cultural relevance, as well as tribal and community concurrence with the values and beliefs embodied by the program.

During the pilot phase, families with domestic violence problems and general family services needs had the same access to Home Base program services as families at high risk for foster placement and families desiring reunification.

In August, 1990, the Laguna Family Services program, including domestic violence services and general family services as well as the Home Base program, was evaluated as a whole in thirty-four cases and found to be successful in preventing a recurrence of domestic violence in 67% of the cases, in keeping 65% of the families together, and in stabilizing 50% of the foster placement reunifications.

According to two 1990 surveys, 90% of the program clients felt that they were coping better with their problems after receiving program services, and 70% of community agencies referring clients to the program rated the program services overall as good or excellent.

In January 1991, the Home Base intervention alone was evaluated in eleven cases where families were separated or at risk of separation, and the intervention was found to be successful in preventing separation in 67% of the families at risk and in stabilizing 80% of the foster placement reunifications.

This paper presents the Laguna Home Base concept in its present form, as it has evolved during the year-long pilot phase. Factors influencing the development and evolution of the program design have included the comments and recommendations of the twenty-three community providers who reviewed the discussion draft, as well as the findings of the evaluation process. The development of the Home Base program continues, as the effectiveness of the intervention strategies is tested and refined, and as new services needs are identified. It is expected that the format and design of the program will continue to evolve. Improving the success rates is the strategic target for 1991.

INTRODUCTION

Some Native American families at Pueblo of Laguna and in neighboring communities of Acoma and Canoncito go through difficult times with their children, which result in the children being placed in foster care or group homes. The Home Base Intervention Team can provide help to keep these families together, or to facilitate the return of family members from placement. The focus is on placement prevention and family reunification through a network of therapeutic interventions and supportive services. The primary objectives are to strengthen, stabilize, and maintain families where children are at risk of imminent placement, to prevent family dissolution, and to promote family reunification and self-sufficiency.

The Home Base Intervention Team of Parent Aides and Family Services worker helps family members increase self-esteem, independence, self-sufficiency, maturity and self-control, and teaches parents ways to improve their skills in communication and conflict resolution, behavior management and parenting. The team members meet with the family to determine which areas are most important to the family, and then offer assistance where it is needed with goal that family members will perceive themselves as surrounded by help to support and reinforce their commitment to goals for change. The emphasis is on defusing conflicts before they

develop into major "blow-ups" which may lead to children being placed out of their homes.

The way the program delivers services focuses on the entire family system, with the ultimate aim of preserving families whenever possible. Family Systems Theory focuses attention on the family as a whole, rather than on individuals, and on the way family members interact with each other and the community. Family Systems Theory is the basis for the Home Base intervention, and the Team Approach is the hallmark of the way services are delivered.

PHILOSOPHICAL FRAMEWORK

The Home Base concept is rooted in a certain set of tenets, beliefs and philosophical assumptions upon which the program is built:

1) most children are better off in their own home;
2) most parents desire to be good parents;
3) most people have an innate capacity to grow and change;
4) it's never too late;
5) in a healthy family, family members have trusting and meaningful relationships with each other, a network of support, and good opinions and beliefs about themselves, and they are able to derive pleasure from life as individuals and with each other;
6) children have dignity as individuals, and a right to adequate nutrition, housing, education and medical care, moral guidance, affection, a feeling of being loved and worthy, a sense of trust, belonging and security, and protection from all forms of neglect, cruelty and exploitation;
7) children need permanency in their family relationships in order to develop into healthy, productive individuals;
8) parents are expected to see that their child has what he or she needs by providing what they can themselves and by making use of available community resources;
9) the community should support parents in this function;
10) the social sciences are not sufficiently advanced to predict accurately which families are hopeless and beyond help;
11) a family's motivation to change can be profoundly influenced by the expectations of the individuals and systems helping them.

A review of a dozen family-centered, home-based placement prevention programs in tribal settings around the country reveals certain key characteristics that the most successful programs have in common:

1) optimism;
2) belief in making a significant service investment in a child's own family and community;
3) a systems approach and a ecological family orientation, using general systems theory to focus on the interactions between family and community rather than on the behavior of individual family members;
4) real coordination and effective case management to remove or minimize barriers in the child welfare system and to facilitate timely and inclusive information exchange and trouble-shooting amongst key persons and agencies, with all psychological and social services integrated toward common treatment goals;
5) small caseloads;
6) accessible and responsive services, giving the family members as much time as they want, when they want it, with 24-hour access to the Intervention Team;
7) flexible services, utilizing the interventions and techniques that prove most effective to give family members a wide range of services when and where they want them;
8) maintenance of services as long as necessary.

These characteristics have formed the basis for the design of the Laguna Home Base Program.

THE INTERVENTION TEAM

Direct Services in the Home Base program are provided by the Intervention Team consisting of the Family Services worker and the Parent aides. The Family Services director provides direction and support. The team approach provides mutual support and opportunities for frequent consultation and feedback between workers to ensure objectivity as well as continuity of service. A clinical consultant is utilized on a regular basis, and issues of cultural relevance are reviewed periodically with cultural advisors.

The Family Services worker develops the overall treatment plan, provides counseling, and helps provide direction and support for the Parent Aides. The Parent Aides help parents learn that it is possible to develop trusting meaningful relationships

with others, sometimes for the first time in their lives. By visiting and being consistently supportive, the Parent Aides can help improve the parent's self-concept, thereby improving the parent/child relationship.

The Family Services director supports the Intervention Team through daily case reviews, regular individual supervision, quarterly formal case reviews, regular individual supervision, quarterly formal case reviews, and coordination of periodic case conferences with providers at other agencies involved in providing services to the family.

Home Base staff provide in-home services through establishing a helping relationship which has the following dimensions:

1) a spirit of trust and friendship;
2) believing in the family;
3) conveying respect for the client;
4) providing unconditional acceptance and positive regard;
5) providing support when the going gets tough;
6) providing continual encouragement and stimulating hope;
7) working together on concrete problems and practical problem solving;
8) giving and receiving love and affection in healthy and acceptable ways;
9) finding ways to increase self-esteem;
10) being available in time of need.

Team members are trained never to accuse parents of abuse or neglect, or cross-examine parents regarding their behavior, and to be open and honest with parents at all times. All decisions affecting the case should be explained and discussed with the parents. Team members should be concerned for the parents as well as the child, and emphasis should be on the need of all family members.

The Family Services director has ten years social work experience, including five years in protective services to neglected and abused children, as well as nine years of human services management in public and private agencies, and holds a B.A. degree. The Family Services worker holds a B.A. degree in Communications and Social Welfare, with three years counseling experience and two years statewide advocacy on low-income and minority issues. One Parent Aide holds a B.A. and has six years experience in law enforcement, including liaison with human services and mental health programs, and holds current elected positions as Village Officer and member of the Board of Commissioners at the Elder Center. The second Parent Aide has two years human services experience, including more than a year of direct experience in domestic violence services. The clinical consultant holds M.S.W. and L.I.S.W. certification, and is a teacher and consultant with more than ten years of clinical practice whose background includes supervision of the psychotherapy and counseling division of a United Way agency. Cultural advisors to the program have included tribal council members and Village Officers, a Laguna alcoholism and mental health counselor, and a former Governor of the Pueblo.

During the pilot phase, staff received 140 hours of training utilizing existing resources available through community educators, Indian Health Service, University of New Mexico, and national conferences. The emphasis has been on family dynamics and on developing a helping relationship without falling into co-dependency or enabling behavior.

Training topics included: therapeutic skills such as active listening, contingency contracting, assertiveness skill development, behavior therapy techniques, crisis intervention techniques and strategies, dynamics of domestic violence and family dysfunction, family therapy techniques, psychotherapy and play therapy with children and adolescents, dynamics of sexual assault, developing self-esteem, and a day of case studies in family therapy presented by Salvador Menuchin. Local tribal people participated in much of the training to ensure theories were applicable to local family situations, and to assist in integrating cultural material into the counseling process.

National conferences included the "4th Annual National Conference on Adult Children of Dysfunctional Families," "Psychotherapeutic Interventions With Ethnic Minority Children and Families," and "Twelve Years of Implementing the Indian Child Welfare Act."

ADMISSION CRITERIA

Families can be admitted to the program through self-referral, referral from any community service provider, by Tribal request or by Tribal Court Order, provided that:

1.) one or more children are at high risk of placement; or are already in placement; or are returning home from placement;
2.) children remain safe at home;
3.) a caretaker agrees to participate;
4.) problem drinking and/or substance abuse are under control;
5.) violent behavior is under control.

Families may be excluded from the Home Base program and a referral may be made or alternative treatment plans may been developed where there is a deep pathology. A triage system using psychological evaluations and clinical consultation helps in identifying situations where children are in imminent danger of violence or a life-threatening situation, or where there is severe, chronic mental, emotional or behavioral disorder, a history of repeated severe, or sadistic abuse or sexual abuse, or persistent violent or volatile behavior.

At Laguna, Home Base techniques and approaches may be applied to situations involving domestic violence or child sexual abuse, but the path to family preservation in such cases may lead through separation. If violence or abuse recurs during the treatment period, separation may be necessary to ensure the safety of family members while continuing treatment is provided.

To ensure that no child is left in danger, staff use the "Risk Assessment/ Observations/Recommendations" developed by the State of Illinois Department of Children and Family Services to determine the level of risk. If a number of risk indicators are present in a family, and the child's safety is in question, even with careful protective supervision, the situation will be referred to the Laguna Social Services Department for investigation. All suspected child abuse and neglect is reported.

All program services are confidential, and the client's right to privacy is spelled out in a confidentiality policy developed in consultation with attorneys of the tribal law firm. Clients are expected to sign a statement that they have been informed of their rights and responsibilities, as well as an authorization for release of information, as part of the intake process. With the exceptions specified, clients give permission for any release of information to another provider, thus ensuring client control over confidentiality.

PROGRAM SERVICES

Need Assessment

The purpose of the Needs Assessment is to determine the family's strengths and needs, the frequency and quality of the interactions between family members, and the resources available, as a basis for developing the treatment plan. During the evaluation and assessment phase, team members observe family interactions, basic parenting, shopping and household operations. Additional background and history may be obtained through contact with other agencies involved with the family. Evaluation examines the composition of the nuclear and extended family, the cultural lifestyle and background, the history of violence, abuse or neglect in the background of either parent, and an assessment of parental functioning, as well as outlining available resources and current coping strategies.

Information and Referral

Program staff are trained to be knowledgeable about all community resources, and referrals are made where other providers may be helpful in a aspect of a family's treatment plan. Formal referral protocols are in place with the Laguna Police Department and the Laguna Service Center for alcoholism and outpatient mental health services. Other protocols are in development with the Laguna Social Services and tribal court. Indian Health Service facilities are utilized for psychological evaluation and psychotherapy. Assistance with pre-employment planning, education and job training is available through Adult Education, Higher Education, and the JTPA program, provided income and eligibility requirements are met. Other resources are utilized as needed to supplement Family Services in carrying out the treatment plans.

The Treatment Plan

The family sets its own priorities and treatment goals in consultation with the Intervention Team. Goal formation should take into account the impact of community forces over which the family may have little or no control, the priorities and needs of the family as a unit as well as of each member, precise clarification and definition of what needs to change and what new skills need to be developed,

medical opinions for any problems which may have a physical dimension, goals of the referring agency, and the realities of community concerns.

Some Laguna families may have difficulty accepting the need of a structured treatment plan with specific goals to be achieved, but these clients may still need and be receptive to many of the services available, in order to stabilize their home situations and strengthen the family. In order to provide services to those families who may not wish to formulate goals and commit to a structured treatment plan, an alternative supportive mode plan is provided, which allows a less structured, more open-ended mode of treatment based upon a less formalized understanding. The supportive mode plan need not include specific goals or measurable objectives, need not specify a client contact, and may incorporate an open time frame or no time frame, reflecting the counselor's intention to provide services rather than the client's commitment to a specified goal.

Counseling

In three recent studies of family-centered programs, family therapy was the most successful intervention, with a success rate of 87.3% in preventing placement during the treatment period, while intensive crisis intervention services proved less successful, with a rate of 76.5% in preventing placement (Nelson, Landsman and Deutlebaum, 1989). For this reason, the Home Base intervention focuses on the provision of individual, marital and family counseling based on family systems theory, treating the family as a whole. Individual counseling is the #1 service, utilized more than all other services by a factor of more than two to one, an 95% of the clients rated the quality of counseling as good or very good.

Parental Tutoring

Private tutoring for individual parents or couples is provided by the Parent Aides, who visit in the home and observe the parents interacting with the children, and then develop an individual learning program tailored to the client's and the child's needs. The learning program may include practical advice and training in homemaking skills, including shopping, cleaning or cooking with the family to demonstrate first hand the accomplishment of the tasks necessary to maintain the home on a healthy basis.

Play/Art Therapy for Children

Play/Art therapy is provided for individual children and sibling groups, utilizing techniques of sand play, make believe including guided fantasy and imagery, puppets, clay, music, and art such as drawing, painting, fingerpainting and beadwork. Analysis of the content of play/art therapy sessions is provided by clinical consultants to ensure that important psychological material receives appropriate treatment.

Support Groups

Support Groups meet weekly for members of families involved in Laguna Family Services programs. A Boys Group, Girls Group, and Younger Girls Group meet after school. Parent Support Groups meet in the evening at the Family Services office, and in the morning at the Laguna Elementary School. Support Group activities are planned to increase self-esteem, provide informal support and allow a forum for group exploration of problems.

Supportive Services

Supportive Services related to treatment plan goals include transportation and advocacy, recreational and leisure activities that promote family unity, life skills, social and traditional skills, as well as a variety of supportive services designed to supply nurturing and reparenting where needed.

Crisis Intervention

A family crisis can present an optimum time for change, and some families can utilize a crisis as a means for changing direction. Night and day access to counselors is available through a 24-hour-on-call Crisis Response Service assisted by the Laguna Police Department. Program staff respond immediately to all crisis calls.

Domestic Violence Services

The domestic violence program emphasizes separation if necessary for the safety of family members. The priority focus is on stopping the violence, and confronting and dealing with alcoholism and mental health issues. Marital counseling is generally not provided in domestic violence cases. Individual counseling by separate counselors is the recommended course to resolve

individual issues and focus on controlling the violence, prior to the initiation of family strengthening services. Some families want to try going through this sequence backwards, by beginning with martial counseling and family strengthening services, in hopes that stabilizing family and social life will result in decreased potency of addictions and reduced incidence of violent behavior. Provided other criteria are met, this is allowed. However, if violence or abuse recur during treatment, alternatives must be considered.

Emergency shelter and related assistance for victims of domestic violence are available through the Laguna Family Shelter, with a capacity to house up to five people. Protective supervision may be provided in the form of three to fifteen hours per week of in-home support, with daily visits to the home as needed. In cases of extreme danger, shelter may be arranged in another community through the statewide Coalition Against Domestic Violence.

TERMINATION AND FOLLOWUP

The philosophy on termination is a key component in the program design.

Current thinking in the home-base field posits a short-term intensive intervention of about 5-20 hours a week over a period of 4-12 weeks, with around-the-clock availability of therapists, low caseloads of 3 to 11 families, a focus on counseling, skill training, and other clinical services, less emphasis on concrete services of transportation, advocacy and client support, and termination after an average service period of about 90 days. This model produces a fairly high success rate of 76%-85% in preventing family separation during the treatment period, and a fairly low success rate of 45%-54% in stabilizing foster placement reunifications. (Nelson, Landsman and Deutelbaum, 1989; Nelson, 1990; Jiordano, 1990.) Recent evidence suggest this model may have a success rate of nil in long-term placement prevention. In three national studies at ten sites, "... brief, intensive family preservation services did not result in a decrease in officially recorded child placements 6-12 months after the termination of services." (Nelson, 1990.)

At Laguna, the Home Base intervention has taken a different form, and is producing different results. The Laguna model is short-term and intensive, providing 5-20 hours per week for 4-6 weeks, with around-the-clock availability of counselors and low caseloads, with a focus on counseling. Major differences are an emphasis on client support, with 53% of the total service hours devoted to concrete services, and a long-term, open-ended maintenance program of family services for as long as services are needed. At Laguna, termination of services is considered when the goals of the treatment plan are achieved, when the initial estimated service period has passed, or when significant improvement in parental functioning is demonstrated. Termination may also occur through voluntary withdrawal of the family from the program. However, as long as the family continues to utilize services effectively and make progress on the treatment plan, the helping network is maintained with no termination for as long as necessary on an indefinite basis if circumstances warrant it. Followup contacts are made at three-month and twelve month intervals to monitor long-term effectiveness, following termination.

The Laguna Home Base results for the pilot phase are a lower success rate of 67% in the short term in preventing placement during the treatment period, but a much higher success rate of 80% in stabilizing foster placement reunifications, and implications of better long-term results, with 80% of terminated families still together after six months.

The 80% success rate of this longer-term intervention suggests that the goals of family preservation, placement prevention and family reunification may require intensive treatment over a much longer period to produce good long-term results.

PROGRAM EVALUATION

The internal evaluation strategy provides the means to analyze and upgrade the quality of services, measure outcomes, support long-range strategy and planning, and to analyze the problem and the target population. The evaluation addressed the following questions:

1) Who is being served by the program?
2) What problems are being addressed?
3) What services are being provided?
4) Are there patterns in the way clients use services?
5) What are the desired outcomes?
6) Is the program producing the desired outcomes?

7) What are the exemplary achievements of the program?
8) Is the program improving the lives of people at the Pueblo?
9) How do staff rate the quality of services provided?
10) How do clients rate the quality of service?
11) How do other agencies rate the quality of services?
12) What does the community think of the program?
13) What are the recommendations for improving the quality of the services?
14) What identified needs of the client population might serve as the basis for long-range strategy and goals?

Evaluation also included an analysis of the incidence of alcohol/substance abuse, child abuse, neglect and sexual abuse, patterns of referral made to and received from other community service providers, incidence of mental health issues, physical and/or emotional violence, spousal abuse, elder abuse, sibling violence, violence of child against parent, and correlation with alcohol abuse as a contributing factor. (Joyce, 1990)

COST ANALYSIS

The average cost per family for Laguna Family Services is $2,956.00.

IMPLEMENTATION OF THE INDIAN CHILD WELFARE ACT IN AN URBAN SETTING

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IMPLEMENTATION OF THE INDIAN CHILD WELFARE ACT IN AN URBAN SETTING

Carol Weins
Patrick Guillory
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The Department of Social Services in San Francisco, The Bureau of Indian Affairs, The San Francisco Superior Court - Juvenile Division, private attorneys and private Indian and non-Indian agencies work together for successful implementation of the Child Welfare Act.

The San Francisco Department of Social Services has one American Indian child welfare worker. She has been given a specialized caseload of American Indian families. The caseworker provides vertical case management services, handling cases from initial referral, (except for emergency response situations) through the court process to the permanency planning stage. She handles a variety of cases including the following:

1. Voluntary agreements, (no court involvement).
2. In home dependency where the child(ren) is a dependent of the court but placed in the home of the parents under the supervision of the Department of Social Services.
3. Out-of-home placements where the child is placed in one of the following:
    a. Relatives
    b. American Indian foster home
    c. Tribal approved foster home
    d. Non-Indian foster home or group home
    e. Residential treatment facility
4. Long term foster care.
5. Legal guardianships.

The workshop will discuss the history in setting up this system and how it is working. In cases that necessitate a petition being filed in juvenile court, both parents and children are appointed legal counsel, either from the public defenders office or a panel of private attorneys. The court recognizes the unique history of Indian tribes with the United States government and the unique cultural and historical background of Indian people and their involvement with the Child Welfare Act, Indian law in general and the working of a tribal government and court system. They are often times knowledgeable of tribal customs and community resources. A commissioner from the San Francisco juvenile court will discuss how this system works, barriers that had to be overcome, reasonable efforts rulings mediation and the culture of the courtroom.

Child welfare services to American Indian families is coordinated by the child welfare worker for the Department of Social Services. She has been successful in developing working relationships with all of the American Indian service providers in the San Francisco Bay area. This includes ICWA grantees (programs that provide court advocacy, counseling, supportive, parenting and tutorial services to families and children) Title V (Indian education programs), alcohol, mental health and foster home licensing agencies. A description of culturally sensitive services and activities that are provided to families and children will be presented.

Where there is a need for a service that is not provided by an American Indian agency, sensitivity training has been provided to non-Indian agencies. One non-Indian agencies has appointed one staff member, instead of several, to handle the referrals from the Department of Social Services on American Indian families. This has allowed the worker from the department to provide on-going individual training to one person who in turn can pass on knowledge to their coworkers. An example of a case plan that includes coordination of services and is activity specific will be provided to workshop participants.

The child welfare worker from the Department of Social Services is responsible for notification to the tribe of involuntary child welfare proceedings involving an Indian child. Strengths and needs of tribal involvement will be discussed in depth in the workshop.

Coordination with the Bureau of Indian Affairs is an asset in locating address of tribes and phone numbers of key contact people. The bureau is also helpful in getting certificate degrees of Indian blood for children. The role of the BIA social worker will be discussed.

The involvement and cooperation of Indian people for the public, private and tribal agencies with the common goal of strengthening and keeping American Indian families together or returning children to their families or tribes results in Indian people making decisions for Indian people.

The workshop is designed to provide a detailed description of the system for implementing the Federal Indian Child Welfare Act in San Francisco and to provide techniques for other communities in setting up a similar system.

"INDIAN AEROBICS!?": INCORPORATING AMERICAN INDIAN HOLISTIC WELLNESS INTO A CULTURALLY RELEVANT AEROBIC DANCE EXERCISE PROGRAM

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"INDIAN AEROBICS!?": INCORPORATING AMERICAN INDIAN HOLISTIC WELLNESS INTO A CULTURALLY RELEVANT AEROBIC DANCE EXERCISE PROGRAM

Dr. Cornel Pewewardy
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Abstract

The idea of combining American Indian philosophy with holistic aerobic dance exercise was used in a gifted and talented summer camp for Indian high school students in Oklahoma. The presentation describes the positive outcomes of that enrichment program, as well as help educators incorporate American Indian teaching strategies toward a natural, fun, and simple approach to aerobic dance exercise.

Introduction

In the community center, gymnasiums, and tribal complexes throughout the country American Indians are finding physical facilities to conduct exercise programs that are becoming culturally responsive to their respective tribal communities. American Indians are rediscovering an age-old method to healing oneself, building self-esteem and self-confidence, and pursuing a holistic wellness program that altogether fits the ideology, philosophy, and thought of American Indian life. An aerobic exercise program called, "Indian Aerobics" is doing just that: incorporating American Indian ideology, philosophy, and thought into a modern aerobic dance exercise program. The purpose of this article is to highlight some of the main idea behind such a unique program. The goal is to help educators and students become more aware of the overall benefits of aerobic dance exercise and the meaning of holistic wellness. Aerobic dance programs like the one to be described is an attempt at making exercise fun, inexpensive, and a cultural learning experience all at the same time.

Showcasing The Program

To put together an exercise program that advocates a culturally relevant pedagogy was a natural and fun charge. The opportunity first surfaced during the summer of 1990 at a gifted and talented summer educational enrichment program for American Indian secondary students in Oklahoma. Explorations In Creativity (EIC) is a summer enrichment program offered to American Indian and Alaska Native students (grades 7-12). EIC provides educational experiences that build on academic and extra-academic topics to enhance self awareness, capabilities and identity as Indians. Indian Aerobics was one of the courses offered in the program. Subsequently, the Indian aerobics concept of incorporating American Indian holistic wellness into exercise programs was presented in workshop format during the National Indian Educational Association, 22nd Annual Conference held October 13-17, 1990, in San Diego, California.

The term "aerobic" means promoting the supply and use of oxygen. The body's demand for oxygen will increase when you engage in vigorous activity that produces specific beneficial changes in the body. Aerobic dance is an exciting and challenging fitness activity that combines exercise (exertion) and dance step (rhythmical movement). It can be totally individualized so that you can move rhythmically to whatever beat (rhythm), whatever tempo (speed), and whatever form of movement you enjoy most--be it jogging, jumping jacks, jazz, or traditional Indian dance (pow-wow) moves!

Culturally Responsive Curriculum

Health being one of the vital elements of any academic curriculum was one of the courses offered during the four-week EIC program over the summer. Traditional American Indian holistic health philosophy was integrated into a modern aerobic dance exercise program. Seeing health as the totality of a person's existence is the holistic view of health. Holistic approaches to teaching and learning represents a rebalancing of educational practice away from its more than half-century old behaviorist/reductionist bent (Komoski, 1990). Such a view is that of American Indian philosophy and thought. That is, both the Western and American Indian methodologies recognize the interrelatedness of the physical, psychological, emotional, social, spiritual, and environmental

factors that contribute to the overall quality of a person's life. No part of the mind, body, or environment is truly separate and independent.

Aerobic exercise forces the brain to switch from rote thinking to creative thinking. While you focus on your body's movement, our mind starts to ramble and inhibitions lift--encouraging an intuitive right brain way of thinking. Most likely, individuals are not going to sit down and compose--but exercise can put you in touch with your own creative potential. The flood of beta-endorphins in the brain can put you into a whole new mode of awareness.

Ross (1990) contends that brain hemispheric research has concluded that the majority of our society emphasizes the functions of the left side of the brain. Consequently, we live in a left-brain world, while research suggest Indian people are more right brain oriented. Ross (p.15) suggest that many Indian people ended up in a "out-of-balance" society. He explains that the culprit was the American educational system that over-emphasizes the function of the left side of the brain.

Brain theory tells us that the brain is continually attempting to categorize and pattern new information with what is already stored (Hart, 1983; Luria, 1975; MacLean, 1978; Pribram, 1971). Whether it is experiencing a random event or a carefully orchestrated classroom experience, the brain functions the same way. Nummela and Rosengren (1986) suggest that the more meaningful, relevant, and complex the external sensory input is, the more actively the brain will attempt to integrate and develop what Hart (1983) calls "program structures" or "prosters".

Dilemma of American Indian Health

The all-American dream of freedom and opportunity for all; including freedom from debilitating circumstances accompanying physical and mental illness, has not yet been realized by the 1.3 million American Indians in this country. It is remarkable, in a morbid sense, that the segment of American population with the longest American lineage still continues to encounter some of the worst health conditions in the nation and possibly the lowest social status even among minorities.

It has been estimated that 50 percent of American Indians are unemployed and of those who are working, a considerable proportion may be underemployed; Indian households have incomes below the poverty level; and Indian homes are five times more likely to be completely lacking in plumbing and nearly 14 times more likely to be without sewage disposal than other homes in the nation (Rhoades, Reyes, & Buzzard, 1987). American Indians suffered an accidental mortality range 2.5 times higher than the United States average. Chronic liver diseases and cirrhosis accounted for three times more deaths among American Indians than that found in the general population. Homicide, suicide, and alcohol abuse also accounted for an inordinate and unacceptable level of preventable mortality (National Institute on Alcohol Abuse and Alcoholism, 1980).

According to May (1987), the average suicide rate for American Indians and Alaska Natives for the period 1980-82 was 19.4 per 100,000 which is 1.7 times the rate for the nation as a whole but lower than it was in the earlier 1970's. Looking at Indian youngsters, the suicide rates for Indians and Alaska Natives aged 10-14, 15-19, and 20-24 were considerably higher. Research suggest that Indian suicide is predominantly among the young is generally true. Conversely, Indians in the older age groups have lower rate than the general population. American Indian youngsters are killing themselves in large numbers at a time in life that Americans typically view as the best of times--early adulthood.

Certain habits of living are associated with the most causes of death. Nearly, all of the ten most major causes of death in the United States, Canada, and other industrialized nations are chronic (long-continued) degenerative diseases, and most of these diseases are related to particular behaviors or living practice. Traditionally, we have depended on doctors and other trained health practitioners to keep us well. But medically very little can be done to help someone afflicted with one of the chronic degenerative diseases. In other words, by the time someone has developed clear-cut symptoms of heart disease, cancer, diabetes, arthritis, or emphysema, it is usually to late for medical therapy to reverse the disease process and restore normal functioning. That is why these illnesses are called chronic and degenerative: once they get started, they tend to persist for life, often becoming progressively worse. The only effective way to deal with these diseases is to prevent them, which in many instances involves improving living habits. Moreover, living habits that help prevent disease also lead to greater health in other ways.

Demise of American Indian Education

In the area of education, even though Indian history in the American educational system is longer than any other minority group, little is still known about their participation rates and achievement levels; and what is known is not very good. American Indians have the greatest dropout rate of all minorities (cited in O'Brien, 1990); and American Indians are disproportionally placed in special education and learning disabled programs (p.16).

The high dropout rate, as well as a high incidence of drinking, substance abuse, civil disobedience, violence, and suicide attempts occurring in Bureau of Indian Affairs (BIA) and public schools, has forced a re-evaluation of the direction of Indian education. Many Indian educators agree with Education Secretary, Lauro Cavazos, (cited in O'Brien, 1990) recent assessment of Indian education: "Native American youngsters have fallen between the cracks of our educational system with tragic consequences."

Methodology

The program enabled participants to find out with little pain and effort what their physical condition is right now, as well as how to improve their condition. Both instructors (male and female) are American Indian; both certified by national aerobic certification agencies; both experienced aerobic instructors teaching varied levels of aerobic dance exercise; and both strong advocates of the holistic method of instruction. Together they have incorporated American Indian culture into an aerobic dance routine by integrating Indian music, traditional dance movements, and numerical counting in tribal languages.

The program provided that participants with the latest research on aerobic dance exercise, all of which makes a significant contribution by correlating oxygen consumption and pulse rate with various types of exercise and the vigor and duration. Research studies show that range of motion exercises (stretches) are correlated with improved flexibility in short periods of time. Instructors show how aerobic dance classes should include a prolonged warm up, a cardiovascular endurance phase, a calisthenics portion, as well as a stretch and flexibility phase. Photography slides and VCR video recordings of live aerobic classes (conducted by the instructors) were shown to help clarify the content area of the exercise program.

Men and Aerobics

More and more society is finding out that aerobics is a co-ed activity. Times are changing and it is becoming more common to see men in aerobic classes, as well as male aerobic instructors. Men are discovering the benefits and pleasures of aerobic conditioning, and have learned to respect the workout, participants, and instructors of aerobic classes.

Aerobic programming can be adjusted to everyone's needs and interest. Aerobic dance suits many aerobic enthusiasts, but not all. The increasing number of men in aerobics is having an impact on aerobic movement style, while the aerobic industry responds to the interest of this special group. More men are hustling to the aerobic room making aerobics a truly co-ed activity.

Indian Music

The culturally relevancy component of the program was incorporated into the aerobics portion by integrating American Indian music into the dance routine and counting cadence in tribal languages. Instead of modern or popular music that is often played accompanying aerobics exercise routines, American Indian music was substituted in its place. For example, during the stages of warm-up and cool-down soft Indian music (like the Indian flute) was played on cassette tape. For the high intensity or impact portion of the workout the type of Indian music used came from the Native American Church (peyote music). Along those same lines or faster paced rhythms, pow-wow songs like the fast war dance music seemed to fit the highest impact levels, while gourd dance, round dance, and/or war journey songs (49) served to slow the pace down depending upon he structure of the workout. Whatever the type of workout movements, there is always a particular Indian song that could be adapted for the purpose of making the entire program culturally relevant for American Indian participants.

Effective Language Education Practices

It has been clear for years that the majority of American Indian languages would soon cease to exist. In 1960, very few young Indian adults in Oklahoma were able to speak an Indian language. Most Indian secondary students in Oklahoma do not speak their tribal language at home (Pewewardy, 1989). Thus, tribal languages are going downhill fast. Indian aerobics counters that by speaking and counting in tribal languages during the workout.

Instead of counting cadence in the traditional American english form of "one-two-three-four" and so forth, "Indian aerobics" counts (of course) in tribal languages. For the first few sessions conducted, an assessment of tribal participants was taken to determine the tribal languages to be used. Once the tribal language(s) was identified, then participants were charged to conduct the research in counting in that language.

Using the whole language curriculum approach, the tribal words for "one," "two," "three," and "four" were sketched on large sheets of paper and placed on the walls where the entire class deemed it most visible. This visual learning style proved to be the most responsible technique of teaching Indian participants. Once the participants began to learn more tribal numbers through counting cadence, they explored substituting simple Indian names and words instead of numbers.

Traditional American Indian Dance

Dancing is a universal instinct--a zoologic, a biologic impulse, found in animals, as well as in human beings. The power of the dance is also universal, both in time and place. Indian dance is not confined to one tribe or to any period of history. In that connection, no where to be found is the unique style of dancing like that of the American Indian. Traditional styles of dancing like that of the American Indian. Traditional styles of dancing of the American Indian are so diverse that it is difficult to describe any, if not one distinct style. Indian dance is a wonderful, beautiful exercise. Traditional dancing is clean, beautiful, dramatic, interpretive, rhythmic exercise; it is possible for all, and is meritorious according to the gift of the dancer. Dancing in one form or another, has always been a critical component in every tribe in the country. Dancing is believed to cure a wide range of psychological and social ills, including depression, antisocial and aggressive behavior, and alcohol and substance abuse. As a result, dancing has been transformed into a widespread social movement for the restoration of self-respect to traditional Indian life.

Dance is the most immediate and accessible of the arts because it involves your own body. When you learn to move your body on a note of music, it becomes exciting. You have taken control of your body, and in learning to do that, you discover that you can take control of your life.

Indian Aerobic Dancing

The instructors demand precision and advocate the participants to be clear and absolutely truthful. When the participants respond--and they do-- they are awarded with "warm fuzzies" (strokes of encouraging words). Moreover, the participants are provided an environment that allows for open expression of oneself during the entire workout. Many times the instructors and/or participants would yell out loud trying to release the inner self of emotions built up during the stressful workday, school day, or whatever life's situation that arises. The type of expression most popular was the so-called cowboy yell: "yeeee' haaaau." Other type of expressions were those used by traditional straight dance and/or fancy war dancers during dance competitions. Besides the vocalization of expressions, participants utilized non-verbal techniques like clapping hands, giving "high-fives", patting the floor with their hands, slapping their thighs to the rhythm of the music, snapping their fingers and doing whatever they felt expressed their emotionally being, while releasing energy in positive methods. With all these types of ways to express oneself, the climate seemed to be quite high. This type of environment gave encouragement to participants that seemed reluctant to express themselves. Once everyone seemed to be working together in the class, it was obvious that each participant was getting a great workout, while having fun at the same time. In essence, that is one of the main objectives of the program.

This unique program is very important because its a way of introducing culturally relevant methods to knowing oneself. This American Indian philosophy of knowing oneself is just another way participants can manage oneself if so desired. It's the beginning of introducing American Indian concepts into modern dance. And dance to American Indians is

a natural expression no matter where it happens: on the aerobic dance floor; pow-wow grounds; in the streets; where ever one can find room to express themselves through dance.

Indian Aerobics is a positive example of how the American Indian (and non-Indian) people can advocate a holistic wellness ideology and philosophy that integrates American Indian culture. This holistic approach to exercise has served to provide culturally relevant pedagogy into a modern exercise dance program that advocates spiritual, mental, and physical well being, as well as focusing on group participation through cooperative learning strategies.

Spirituality and Health

This holistic wellness approach to aerobic exercise recognizes that for many American Indians spiritual feelings and experiences--those which are not necessarily achieved by the application of logic and critical thought but which are more intuitive and subjective--can affect a person's state of wellness. This idea is not new to the traditional American Indian worldview, but contrary to much of the mainstream cultures' modern thinking about health, which tends to view states of wellness and illness as being affected only by physical processes that are amenable to objective, scientific study. Traditional American Indian holistic wellness acknowledges that an objective, scientific explanation of the workings of the physical body contributes to a greater understanding of the mechanisms of disease and hence illness prevention and the attainment of health. Moreover, it recognizes that many people have inner experiences that are subjective, mystical, and for some religious, and that these experiences may affect health as well.

By recognizing that the spiritual aspects of being can be important to health, the American Indian holistic wellness philosophy is in accord with such centuries-old traditional philosophies as the Hinduism of India, Taoism of China, and Buddhism of Tibet, Japan, and other Asian countries. The American Indian holistic wellness worldview shares with Eastern, as well as Western philosophies the belief that spiritual experiences can engender feelings of compassion, peace of mind, and harmony with the environment. These feelings are believed to be the cornerstone of health, for they represent a balance between the inner and outer aspects of human experience.

In practice of holistic health, as in the practice of American Indian philosophy, introspection and intuition are paths to spiritual experiences. Because so much of American culture and nearly all of the educational curriculum are based on cognitive, rational appraisals of experience, many Americans cannot understand nor appreciate the richness of American Indian philosophy: subjective; intuitive, or spiritual modes of experience.

Like Indian running, Indian Aerobic participants can explore the ancient roots of American Indian games. Equally as important is that American Indian youth can enact tribal myths and create a bridge between themselves and the forces of the universe.

Accordingly, Indian aerobics harmonizes new experiences with old-traditional ways in a rich culturally responsive, non-threatening environment that helps Indian and non-Indian participants learn more naturally and fully. Thus, a sociocultural supportive context will enable American Indians to make significant contribution to the mainstream while retaining their sense of identity within their own culture.

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MENTAL HEALTH NEEDS OF THE REUNIFIED CHILD: STRATEGIES AND INTERVENTIVE/PREVENTIVE TECHNIQUES

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MENTAL HEALTH NEEDS OF THE REUNIFIED CHILD: STRATEGIES AND INTERVENTIVE/PREVENTIVE TECHNIQUES

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The return of aboriginal children to their communities, referred to as reunification, is a highly controversial and debated subject in Canadian society. Review of the literature reveals that systematic research is lacking at almost ever level of the reunification process. Yet, decisions regarding the mental, physical and emotional well-being of these children are determined by service-providers who lack an adequate knowledge base to facilitate this process.

The purpose of this paper is to examine the reunification process in terms of the mental health needs of aboriginal children in trans-racial substitute care. The authors' position is that, contrary to current belief, the so-called reunification process is but another level of a much larger issue. That is, casework must focus upon maintaining cultural continuity from the moment a child enters the system of child welfare and substitute care. Casework strategies need to be developed which facilitate maintaining cultural continuity for indigenous children, based upon individual needs. The strategies proposed within this paper offer solutions which support and foster Native ethnicity, in various trans-racial settings.

THEORETICAL ORIENTATION

Over the past two decades, essentially two arguments have been generated in terms of the adverse effects resulting from Indian children being placed in trans-racial settings. One argument has its foundation in the colonization model and institutionalized oppression. Here, the child welfare system can be traced to assimilationist policies which characterized early Indian-White relations (Cross, 1986; Johnson, 1983; Hudson & McKenzie, 1981;Miller, et al, 1980; Hull, 1982; Sullivan, 1983; Slaughter, 1976). Initiated by "An Act For The Gradual Enfranchisement Of Indians" in 1869, (Tobias, 1976), this policy was manifest through institutional means of undermining traditional customs and practices. In the early 1800's, the responsibility of assimilation was left primarily with the missionaries (Miller, et al, 1980). The principle objective of the missionaries was to Christianize and assimilate the Indians into white society. This task was initiated by an assault on the traditional religious beliefs.

Many of the traditional belief systems on which child-rearing practices depended were displaced by Christian or other beliefs. These new beliefs introduced parents and guardians to different child-rearing attitudes, such as the concept of original sin and 'Spare the rod, spoil the child'.

These concepts differed vastly from the traditional concepts about children and physical punishment. Because Indian people were expected to give up their traditional spiritual beliefs, traditional child-rearing values and practices were all too often lost as well (Cross, 1986:286).

Later, the introduction of boarding or residential schools separated Indian children from their families and communities, resulting in further destruction of the traditional way of life. Through children, culture is transmitted to future generations. By removing children from their traditional society and placing them in a foreign society, where a different set of values, philosophies and practices operate, their ability to maintain and pass on their traditional culture is destroyed.

These schools, which were often located hundreds or thousands of miles from the children's homes, frequently prohibited the use of Native language and tribal customs, required the wearing of uniforms, and enforced rules in an authoritarian manner completely divorced from traditional Indian child-rearing practices (Hull, 1982:311).

The destruction of Indian culture has often been equated with "cultural genocide" (Carasco, 1986; Johnston, 1983). Assimilation was the policy, with its manifestations rooted primarily in the wholesale removal of Indian children from their communities. This was first demonstrated in the boarding schools of the early 1900's where Indian children were separated culturally as well as geographically from their families, and more recently, in the child welfare system. By 1950, when it became apparent that previous forms of assimilation were ineffective, the child welfare system was extended to Indian

people, whereupon the separation of families continued (Sullivan, 1983; McKenzie & Hudson, 1981; Hull, 1982).

A second leading argument discouraging the cross-cultural placements of Indian children focuses upon mental health issues.

MENTAL HEALTH NEEDS

A comprehensive review of the literature shows that children in foster care are maladjusted (Prosser, 1978) and those children coming into care have probably already been adversely affected by the negative effects of neglect, abuse or extreme parental inconsistency that Rutter has termed "privation" (Rutter, 1972). A study by Hormick et.al. (1984) found that children recently admitted to foster care displayed significantly difficult behavior compared to normal children in the same age grouping. This view is further substantiated by Steinhauer (1980) who states that circumstances in the child's natural home induce deterioration in the child's mental well-being prior to being placed in foster care. However, numerous studies identify that upon remaining in foster care certain characteristics emerge such as an inability to trust others; a sense of worthlessness and rejection; low self-concept; low self-esteem and identity problems (Fellner and Solomon, 1973; Steinhauer, 1984; Rutter, 1972; Fruseliotis & Russell, 1984). In general, children coming into foster care are usually already disturbed to some degree and those children remaining in foster care are at high-risk for further manifestations of emotional and psychological problems.

The native foster child shares many of the problems experienced by foster children in general. In addition, there are a number of areas which complicate and probably worsen the situation for native children and their families.

First, the rate of Native children in care in Canada is five times the national average. Further, native children tend to be in care longer than non-Native children (Andres, 1981). Fellser and Solomon (1973) contend that the longer foster care persists, the greater the adverse effects upon the child. Findings by Levitt (1981) show that children in care longer than 18 to 24 months have a significantly reduced chance of returning home or of being adopted due to lack of continuity. In many cases children who remain in long-term foster care often experience a sense of detachment with their parental figures due to sporadic contact. Lacking continuity, these children have developed a psychological attachment with their foster family. Once regular contact resumes with their natural family, attachments are strengthened, while in turn making their placement in foster care more difficult. As a result these children may suffer from adjustment difficulties or adjustment disorders. Also, the longer these children are separated from psychological parents, the more likely that they will experience conflicts of loyalty (Poulin).

Secondly, both Canadian and American studies show a higher rate of placement for Native children as compared with non-Native children (Andres, 1982; Hepworth, 1979; Hull, 1982; Fisher, 1983). Separation from the natural family, or significant others in the child's life to whom a child has become attached, is traumatic.

The pain of multiple separations from natural families and surrogates leaves the child with an overwhelming fear of rejection (Topper, 1983). It is often difficult to detect the suffering of children in regard to separation issues, since most children tend to deny their suffering and pretend nothing has happened, due to the painful experience. Some of the signs to indicate separation suffering are:

a) The good child - the child may believe he/she was taken away because he/she was bad and being perfect or good will bring the family back together.
b) Little interest in play - sign of depression
c) No attempt to form relationships
d) Clinging to special articles - signs of loneliness and fear.

Most psychoanalysts agree that continuity of relationships, surroundings, and environmental influences are essential for a child's normal development. Multiple placements disrupt the child's sense of continuity and impair their ability to let themselves trust others and develop close personal ties (Fishler, 1980). Further, Fishler (1980) states "...that most Native children in long-term foster care must endure three or more placements, each move adding its increment of harm." (p. 345).

Finally, Native children who have been separated from their families and communities for any length of time suffer from identity problems. Triseliotis &

Russell (1984) believe that children in care have suffered some deprivation of their basic needs and that those children that remain in care are additionally at-risk of losing their sense of identity and feelings of personal worth.

The relationship between self-image, self-respect, self-esteem and mental health has been studied by a number of people. John Triseliotis (1983) has considered the identity needs of adopted children and foster children in some detail, identifying the psychological, social and cultural influences that combine to build an integrated and unified self. These include childhood experiences of feeling wanted and loved within a source environment, knowledge of personal history and background, and the experience of being recognized by others as a worthwhile person.

Triseliotis further emphasizes that the healthy development of the child's personality is, to a large extent, dependent upon repeated emotional and other learning and social experiences throughout childhood, confirming this recognition. If a child is denied these forces in their placement, then the development of a secure identify is undermined and damaged. Triseliotis's work, along with Colon (1978), with adopted children also shows how the past contributes to the formation of the whole self and how we have a need to know our personal history and that of our parents and ancestors. Triseliotis also quotes the work of Goffman and others who indicate that self-concept is affected by the perception of ourselves as others see us; and, he has developed the concept of a "spoiled identity" to signify the impact of stigma and labelling on individuals and minority groups who are seen to depart from or defy the accepted norm. All this work assumes special significance when considering the needs of Native children in general. It's especially significant for Native children who are growing up in care and placed in non-Native children who are growing up in care and placed in non-Native foster homes with little, if any, contact with extended family members and limited knowledge provided on heritage, culture, family, and personal history.

These Native children, who have been separated from their families and community for an extended period of time and placed in non-Native foster homes, find themselves in a position whereby they are unable to speak their tribal language; have become accustomed to a set of mannerisms and norms different from their native community; and use a different world view from their tribal families, peers and community members, At the same time, these "assimilated" children are viewed by the dominate society as stereotypic Indians and are denied the white societal role they have learned (Walker, 1976). In addition, research has shown that non-Native foster parents cannot prepare the Native child for the prejudice that exists (Kimelman, 1985). All of these factors can make returning to the Native community difficult. Native children become physically and socially distant from their natural families and community.

The identity crisis for children becomes most apparent at the time of adolescence. During the adolescent stage numerous changes begin to happen. Old rules lose their meaning and suddenly the world seems different. There is a certain amount of conflict between adolescents and their parents, much of which results from the young person's search for identity. The psychosocial development in adolescence is most strongly characterized as a search for personal identity (Erickson, 1968). Erickson proposes that the most important task of the adolescent is to find out "Who one really is" Erickson (1968) also describes the search for identity in adolescence as the fifth crisis of development: Identity versus role confusion.

However, Bandura (1977), one of the strongest critics of the model of adolescent crisis, concludes that many young people are socialized into the roles they will play as adults. The main suggestion by Bandura (1977) is that some adolescents behave as society expects them to behave and if a negative image is reinforced by the mass media, cultural expectations may force adolescents to act accordingly. Hopps (1982) suggests that it is people of colour who "face a pervasive kind of oppression and discrimination because of racial stereotypes associated with and indelibly marked by the colour of their skin" (p.3). Doug Sanders wrote a paper for the Law Reform Commission of Canada claiming that problems related to racial identity in an adoptive home could be reinforced by obvious differences between parents and child. The examples he used were skin colouring and other cosmetic differences. Maita Sotomayor (1977) presents the view that language, culture and ethnicity plays an important role in the formation of the self-concept and coping skills. She states that the self-concept can suffer irreparable damage if the socialization process prevents significant and

familiar symbols to be present and reinforced at various levels of experience. The sense of belonging, crucial in the development of the self concept, becomes blurred if one's language, cultural patterns and ethnic experiences are not reflected and supported, as well as, given negative connotations in the environment (Sotomayor, 1977). All of these factors in relation to the native adolescent raised in a non-Native environment, without the benefit of protection from their own ethnic group would seem to account for many of the negative behaviours displayed by these children, which ultimately lead to and are manifested in alcohol and drug abuse, conflict with the law, peers and educational system, depression and eventual suicide (Kimelman, 1984), placement breakdowns, and placement with extended family within the Native community.

WESTERN VS. TRADITIONAL

Child welfare was initially developed as a protective service for children whose well-being was at-risk in their natural environment. This principle embraced the concept of universality and need (Thomlison & Foote, 1987; Kessel & Robbins, 1984; Hudson & McKenzie, 1981; Keelough, 1980). Standard techniques and approaches were used by non-Native social workers who lacked knowledge and understanding of Native culture (Carosco, 1986; Lewis & Ho, 1975).

The lack of acknowledging the possibility that another appropriate set of norms existed reflects the stereotypical image attached to Indians and the general devaluation of their positive attributes (Sullivan,1983; Hudson & McKenzie, 1981). In fact, most literature dealing with the area of "Indian child and family welfare focuses on the negative aspects of the Indian family" (Ryan in Sullivan, 1983:83; Blanchard & Barsh, 1980). Kessel and Robbins (1984) add that use of alcohol often served as proof of neglect despite the fact that drinking rates for Natives and non-Natives were alike. Similarly, Johnston (1983) reported that in cases where drinking rates were similar, "parental neglect was rarely applied to the non-Native person to justify the apprehension of children" (p.77).

The principle of universality and need is exemplified in cases where Native children were apprehended by non-Native social workers. Johnston (1983) discusses the "sixties scoop" whereupon large numbers of children were apprehended with the justification of protecting them from "crushing poverty, unsanitary health conditions, poor housing and malnutrition" (p.23). Other authors contend that apprehension was based on vague laws such as "social deprivation" and "emotional damage" caused by parental neglect (Bagley, 1985; Kessel & Robbins, 1984; Blanchard & Unger, 1977). This concept of protection has often led to the implementation of a policy which broke up intact families. Were the services preventative in nature, children would not necessarily be removed from their natural families; rather, assistance could be provided with the family intact. This would be particularly applicable in cases where neglect, not physical abuse, was the basis of apprehension. In fact, most Native children are removed for reasons other than physical abuse (Johnston, 1983; Miller, Hoffman & Turner, 1980). The act of removing a child from the domain of her or his natural environment not only affects the mental well-being of the child (Thomlison & Foote, 1987; Carasco, 1986; Hull, 1982; Johnson, 1978; Berlin, 1978; Blanchard & Unger, 1977; Topper, 1979), but certain problems arise within the individual family. As Johnson (1983:60) points out:

"...existing psychosocial research shows a high correlation between tribal children's removal from tribal cultural settings and subsequent problems with parenting, alcoholism, and suicide."

The natural system, such as extended family, could be utilized as a "protective" measure, such as providing substitute care, while the natural parents receive guidance/attention from other features of the natural system (i.e., spiritual healing). Continuity would then be maintained.

The concept of continuity is a key focus among writers of child welfare practice. The standard approach used by westerners is identifying and treating child/family pathology while ignoring underlying causes of family stress such as poverty (Ricks, Wharf & Armitage, 1990; Bagley, 1990; Bush & Goldman, 1982).

The permanency principle was initiated with the intent of providing children with permanent parents as well as reducing the risk of multiple placements (Bush & Goldman, 1982). This policy is exemplified in Alberta's "2 year rule" whereupon

children who have been in substitute care for two or more years, accumulatively, are then made subjects of the Crown (Alberta Child Welfare Act, 1984).

Preventing multiple placements and providing a permanent family are valid principles in child welfare; however, the principle of permanency undermines an equally important principle of familial continuity and sets up a preoccupation on the child while ignoring the family and/or community. In their critique of permanency principles of child welfare, Bush & Goldman (1982) identify two problems inherent in practice, directly resulting from this permanency principle:

1. at the moment a home begins to break up, the permanency principle shifts the state's burden of responsibility from maintaining the home to providing permanence for the child;

2. while the child is in temporary care, the principle gives the state no particular reason for maintaining contact with, or improving the situation of the child's own family in preference to pursuing other options that might lead to permanent placement (p. 226).

As noted earlier, aboriginal children were typically removed physically, as well as geographically, from their families. In those cases where children could not be maintained within the nuclear or extended family, they were generally placed in trans-racial substitute care. Little, if any effort was made to maintain continuity of cultural, familial or religious beliefs; rather, aboriginal children were expected to adjust to the lifestyles, values and principles of their trans-racial caregivers.

In Western society, providing substitute care has traditionally been an altruistic behavior. Families foster children presumably because they enjoy children and wish to contribute to society by providing a child with a family. This has not always been the case. Historically, children were the responsibility of the state (i.e., orphans) and families typically accepted this responsibility if they could utilize a child's services such as in farming, cooking, babysitting, etc. (McGillivroy, 1984).

With industrialization, came reforms in child welfare and an eventual move away from orphanages. The concept of children's rights also emerged. Families who provided substitute care, however, continued to be recruited based upon the altruistic philosophy.

In many cases, child welfare agencies experience much difficulty in the recruitment and long-term maintenance of foster homes. These agencies would be hard-pressed in requesting foster families to undergo in-depth or long-term training. It is equally difficult to demand services from families who are basically operating on a volunteer service. More recently, the need to professionalize fostercare has been a successful movement. Once professionalised, families could be remunerated for their services. Conversely, agencies can expect certain services necessary to meet the needs of children in care.

Providing substitute care was a typical function of the natural system and has been another area replaced by formal child welfare services. Several factors characterize the low utilization of Native foster homes. One is association with the stereotype that children raised in Native homes will be subject to "impoverishment" and "socially disorganized circumstances" (Ryant, 1984). This may partly explain why most foster homes are white and middle class (Thomlison & Foote, 1987; Johnston, 1981). Foster care policies reflect Western values of child care, creating obstacles for potential fostercare homes (Thomlison & Foote, 1987; Johnston, 1983; Hudson & McKenzie, 1981; Johnson, 1981; Sanders, 1975).

Standards for fosterhomes tend to focus on material conditions such as "separate beds for children, a reasonably stable income, specified square footage, hot and cold running water, and indoor plumbing" (Johnson, 1981:438). Further complications arise through bureaucratization and red tape (Johnson, 1981). Given these considerations and the fact that Native children experience significant difficulties as a result of being placed in non-Native settings, it is of critical importance that the family be utilized in the recruitment of Native foster homes.

In western society, the family consists primarily of three generations -- the grandparents, parents, and children (Johnson, 1983; RedHorse et.al., 1978). The responsibility of child-rearing is maintained basically within this nuclear family unit and is reflective of the principle of private property (Goodluck & Short, 1980). Children are considered as property in the sense that it is the nuclear family's responsibility to discipline, nurture and support their children from birth to the legal age of consent (i.e., age 18 years). This western value is in direct conflict with Native traditional values. The

Indian family is an extended family, with aunts, uncles, cousins, maternal and paternal grandparents (Johnston, 1983). Within this kinship network lie roles and responsibilities conducive to the well-being of children. For instance, in some cultures, the natural mother's brother plays a particular role in the child's upbringing, such as in the area of discipline and instruction (Blanchard & Barsh, 1980). Similarly, a child may have several "mothers" whereupon he or she may reside with any one of them for a particular length of time. The responsibility of caring for children rests not only with the immediate family, but also (and perhaps primarily) with the extended family network and community. The community views the birth of a child as representing the "renewal and preservation of life" (Blanchard & Barsh, 1980:350). Adding new support to the community, the newborn child is as important as those already born. Blanchard and Barsh (1980) describe children's relationship with their community:

"Children are encouraged to develop a sense of community that is complete. The experience of community is a tangible one, occurring in close contact with many people who praise, advise, guide, urge, warn, scold, but not important, respect children. The lessons children learn make sense because they are directly related to the life of the tribal community and children's place in that life (:351)."

The view of the child as being an "active" participant sharply contrasts with the Western concept of the child as being a "passive" participant. Western social scientists commonly believed that children occupy a passive role in their socialization, often referred to as "blank slates", to be molded through parental instruction (Love & Money, 1987). This model assumes that if deviance occurs, such as alcohol or drug abuse, criminal activity, etc., it is the result of faulty internal processes caused by personal experiences (i.e., within the family). This model leaves room to justify antisocial behavior by blaming the family rather than external forces.

The Indian view of the child as being an active participant places the child in a different perspective. The child, having influence over his or her world, is subject to those same influences. Hence, deviance is believed to be the result of external social processes (Blanchard & Barsh, 1980). Further, in the being an active participant, the child is not a "blank slate" rather, part of the process of "becoming". Hence, the child is viewed as being a great contribution to the community as an active participant and as a continuation of the Indian way of life.

Traditionally, child welfare was unnecessary, as the natural system had many safeguards built into it for the protection of children against abuse or neglect (Cross, 1986). Attitudes held toward children are synonymous with attitudes toward land (Goodluck & Short, 1980). The land is viewed as being a gift from the Creator, as are children (Cross, 1986), and cannot be "owned" or possessed by any one person. It is the responsibility of the people to respect and honor Mother Earth, as they would the Creator.

Similarly, the Indian does not view a child as personal property, but as belonging to the community as a whole. Attitudes toward the land base and toward children are parallel in that one does not terminate one's relationship with either, but provides support, sustenance, and nurturing to ensure continuity (Goodluck & Short, 1980:173)

The responsibility of care for a child does not cease at a particular age. A child, for instance, is prepared very early in life to make decisions concerning his or her well-being. Native children are thus accorded a greater degree of autonomy and independence than western children (Johnston, 1983). While westerners have often labelled this practice as being overly permissive or neglectful (Hull, 1982; Johnston, 1983), it is reflective of the pacifist approach in rearing children. The process of imitation or role modelling is a cultural norm within Native communities and was often used as a form of social control (Johnston, 1983; Hull, 1982).

A pacifistic approach to child rearing meant that Native families adopted other means of socializing and disciplining their children. It was believed that children learned by imitation, so the concept of the adult-as-role-model was fundamentally important. The development of positive and appropriate behavior in children was fostered by public opinion and the use of community approval or disapproval. Humor and teasing were employed as a means of disciplining in both Indian and Inuit society (Johnston, 1983:68).

The concept of modelling contrasts with the western practice of shaping which was based on B.F. Skinner's theory of operant conditioning and was practiced among westerners as a form of teaching

desirable behavior (Brant & Brant, 1983). Shaping involves rewards and punishments and works in such a way that when a child performs a desired behavior he or she is rewarded (i.e., praised). For instance, a non-Native mother may spoon-feed a child for several months and eventually hold the child's hand and "show" the child how to use the spoon. One day the child will use the spoon on his own and that will indicate to the mother that the child is ready to perform this task independently. Underlying this practice of modelling rests the paradigm of non-interference. All people, regardless of age or sex, are treated with respect, independence and autonomy. Behaviours that are threatening, cajoling or demanding (i.e., as in demanding a child perform a task before he/she feels he/she is ready) are improper and unacceptable (GoodTracks, 1973). Personal power is respected and valued. This principle is more so applied on an individual, rather than collective basis. In terms of the collective, there are rules and rigid structures that are strictly adhered to and reinforced through ritual. Ritual balances non-interference and was practiced through, among other things, "the mechanisms of shaming, rather than by the process of personal responsibility and internal control by guilt" (Patterson, in Brant & Brant, 1983:41). Punishment, used by Western Society to shape or control behavior, is also seen as a form of interference and therefore rejected by Native people; voluntary cooperation is the practice, (Patterson, in Brant & Brant, 1983; GoodTracks, 1973).

The western concept of intervention is viewed as interference by the Native community and is responded to by both withdrawal and passive remittance (Hull, 1982; Wax & Thomas in Lewis & Ho, 1975). A more acceptable and effective approach would be the utilization of the natural system. When working with Native communities, social workers can avoid interfering by consulting with elders, medicine men, extended family and perhaps ministers.

This approach may result in keeping families together and building good working relationships between the social worker and the community. The foundation of any good relationship is trust and respect. This cannot be attained by ignorance and interference. Social workers have genuine concerns about communities, families and children; however, much harm can be done under the precept of "doing what's best for Indian children".

RELEVANCE TO SOCIAL WORK

Currently there is a disproportionally large number of Native children in care compared to non-Native children in care in the Province of Alberta (Alberta Child Welfare Information System, 1988). Statistics produced by the Alberta Child Welfare Information System as of January 31, 1988 showed that there were 2,628 Native children in care in the province of Alberta versus 7,462 non-Native children in care. This means that 18% of all Native children in the Province of Alberta are in the care of the Alberta Provincial Government compared to .0003% of the children from the non-Native provincial population. The most recent child welfare data shows that Native children are over-represented in all aspects of the child welfare delivery system. There are more Native children under apprehension, supervision orders, temporary guardianship orders and permanent guardianship orders (Department of Social Services Child Welfare Information Services, 1988). The Native child tends to remain in care longer and be moved more often than non-Native children. For those children who are adopted, it is claimed that 78% are adopted by non-Native families (Hornick & Burrow, 1986). Of note, there are no statistics maintained by the Department of Social Services to indicate how many Native children who were adopted return to child welfare status due to adoption breakdowns. Native children have been continue to be over-represented in the child welfare system.

Based upon the above statistics and problems inherent in the child welfare system, child welfare agencies need to re-evaluate currently held policies relating to the reunification process of Native children in care. There is little doubt that the way reunification cases are handled by various professionals can either negatively or positively affect the child's adjustment. Professionals involved in the reunification process include but are not limited to the following: child welfare workers, band counsellors, mental health therapists, foster parents, band delegates, district office managers, and extended family members. All of these individuals have an important role to play in the handling of reunification cases. However, it is the child welfare worker's responsibility as the case manager to aid the child in his/her placement and adjustment through the reunification process. The attitudes, level of understanding, and knowledge base of factors related to reunification that social workers have in general unquestionably affect not

only the way a case is handled but may also contribute to whether placement and placement stability will be an expected positive outcome.

MAINTAINING CULTURAL CONTINUITY

In the event that aboriginal children are placed in cross-racial substitute care, maintaining familial, religious, social and cultural continuity is an important factor in reducing further trauma. There are certain characteristics typically present in children who come into care, in general, such as sexual abuse, victimization, etc. While these treatment issues must be addressed, this should not reduce the need to maintain cultural, familial, social or religious continuity.

Preserving and maintaining continuity should be included in the initial case-planning phases between the natural family, child, fostercare family and caseworker. Specific goals and means of attaining these goals should be identified and agreed upon. Methods of maintaining continuity may be developed by the following points:

Extended family map:

When a child enters the system, an extended family map should be developed in order to identify significant other.

Genogram:

Age permitting, the child should be interviewed to identify social and family networks which are valuable components of maintaining cultural, family and social continuity.

Family group meetings:

This will give the worker the opportunity of meeting the child's family and significant others, as well as developing trust with the family. Once basic trust has been established, the worker can gain information, such as level of committedness of certain family members, who is in a position to visit the child, and if any risks are present (note: Risk is age-dependent -- i.e., a situation which may present a risk to a 3-year-old may not present same risk for a 13-year-old).

Consistent, regular contact with natural family: Research suggests that children, in general, lack consistent contact parental figures. In other cases, service providers and caregivers feel the child may be emotionally traumatized by contact with parents who have certain characteristics (such as mental illness or severe alcohol problems). Familial continuity with natural parents and siblings is extremely important, even if this means supervised or shorter visits. Attempts should be made to create a normalized atmosphere during visits (i.e., if possible, avoid office visits).

Family friends:

Part of the genogram should include close friends (i.e., school friends). The families of close friends may be able to include the child in cultural events etc., particularly in the event that the child has few extended family.

Language:

If the child speaks his or her native language, every effort to preserve the language should be made. This can be accomplished through contact with extended family members or membership of local Native organizations such as Indian Friendship Centers. Friendship Centers are open to all people, regardless of their race or gender, and often offer recreational programs for youth and adults.

Religious and/or traditional healing practices:

Depending upon the child's religious orientation, he/she may be accustomed to traditional healing practices such as sweats, face-painting, smudging with sweetgrass, attending lodges or spiritual gathering. If this is the case, efforts should be made to have the child involved in this process. If the family is not utilizing these natural healing systems, caseworkers can access this through the use of community elders or community youth workers. Such access may further be initiated through the bank social services.

Traditional names and ceremonies:

While many Indian people have Christian names, many also have Indian names, often given at birth. Foster parents and caseworkers should be aware of this as well as whether the family utilizes traditional naming ceremonies in certain rites of passage.

Family and community resources:

If a child has few family and/or community resources to access, other types of resources can be developed by caseworkers. For instance, Native families who are not in the position to provide substitute care on a day-to-day basis, can be utilized for weekend visits on a fee-for-service basis. These "host families" may be contacted to work with the natural families (i.e., access) as well as help facilitate cultural and social continuity.

These types of relationships may develop in such a way as to become part of the child's support network when he or she is reunited with the natural parents or in the system on a long-term basis.

Role models:

Exposure to positive role models and media images is an important factor when a child is placed in a cross-racial community. When foster families take a healthy interest and active participation in a child's ethnic background, a child is less threatened and more secure in the new environment. this may further reduce typical feelings of alienation, racial loyalties and justification.

Therapeutic groups for children:

Many needs can be met through therapeutic groups which focus upon issues such as separation, loss, coping skills, similarities, differences and appreciation of Indian and western cultures, etc. These groups can continue, following the return of the child to his or her natural family, creating additional support for the child.

Symbolism:

Symbolism of all forms is a powerful medium in transmitting and maintaining ethnic identities. Developing an appreciation for cultural symbols models an appreciation and respect for that particular culture, reducing alienation for the child of that culture.

REUNIFICATION OF CHILDREN IN LONG TERM CARE

As noted earlier, reunification of aboriginal children is not a mutually exclusive concept; rather, it is a concept based upon a continuation of events, philosophies, and experiences. There are many factors influencing the direction of reunification ultimately of which the child determines his or her path. While reunification should not be forced upon any child, he or she should undergo some type of formal assessment along with his or her substitute family, to determine exactly how reunification will best be met if the child is strongly resistant to this assessment this, may in itself cause reason for exploration. While refusal should be respected, assessment should still occur. Variables which should be taken into account during the initial reunification evaluation are:

1.) child assessment
2.) parent and extended family access
3.) benefits of physical return

Goodluck and Brown (1979) offer a detailed assessment and evaluation tool for reunification purposes (see Appendix I).

These assessments provide the baseline by which reunification is directed. If a child is experiencing identity confusion and/or cultural alienation (i.e., at adolescence), the process of reunification may be a difficult task. However, significant people involved with the youth can have a powerful impact and influence upon the reunification process. The authors' offer several suggestion based upon literature reviews as well as personal experiences in the reunification of tribal children to their communities.

Cultural awareness

It is often the perception that Indian children know everything there is to know about Indian culture. Native children who have been raised in western society often come to know Indian culture through the perception of westerners or the status quo. For those children who have little knowledge of their history, culture, etc., the foster family must take an active role in developing awareness.

Life history books

Life history books can become powerful tools in assisting children with identifying who they are, how they came into care, as well as identifying unresolved past issues for treatment purposes. Life history books may be both informal and formal, using such mediums as pictures, family maps (including extended family or clan members), souvenirs, etc.

Attendance at social/community events

For those communities that are geographically near Indian communities, there are often cultural centers and/or events for both rural and urban populations. These should be slowly integrated into the family's recreational agenda. The Native social worker is recommended to participate in direct contact type of events, in order to facilitate healthy comfort levels.

During the phase of direct contact with the youth's tribal community, the Native social worker may benefit the child by accompanying him or her to tribal community events such as pow-wows or Indian days. This offers the youth anonymity and an opportunity of identifying family members from a distance.

Extended family/community contact

Following the assessment and evaluation of community and/or extended family members, the social worker will have developed a working relationship with significant others. These significant others are identified to the child and introduced in a non-threatening environment. The nature of the case plan will direct the level of involvement from foster families.

Grandparent/elder adoption

Symbolic adoption of a tribal grandparent or elder can have a significant impact upon the child and substitute family as well as becoming part of the support network system.

A grandparent or elder can have important functions such as teaching historical and cultural information, accepted norms and behavior

appropriate for that particular tribe, as well as becoming a valuable resource for the caseworker. Elders can be utilized as mediators in tribal communities.

Language

Knowledge of the tribal language is a desired factor in facilitating a child's familiarity and comfort with his or her tribe.

Groups for youth

To explore and develop a healthy awareness of western and tribal ethnicity.

Rediscovery camps

Rediscovery camps are becoming popular throughout Canada and are based upon Native philosophies and values. These camps require Native leadership but also share their roles with non-Native people. Children of all ethnic origins are welcome.

SUMMARY

In conclusion, the reunification process offered is not intended to be "textbook theory". That is, children cannot be "trained" to be culturally oriented. Culture is transmitted through experiences, identification through group membership, and social interaction, and is a life-long process. The major thrust of the reunification process is the following:

a) The child must actively participate vs. passive participation.

b) Case plans must identify clear strategies for cultural continuity and/or reunification.

c) Use of the holistic approach vs. linear, as the foundation of case practice.

d) Substitute care (whether formal or natural) and a sense of permanency are necessary; however, continuity of social, ethnic, religious and familial relationships is equally important for the healthy adjustment of children in care.

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APPENDIX I: (Adopted from Goodluck, C. & Brown, 1983).

Goals

A. Permanent home. The underlying goal for a children should be to arrange a permanent home of the child as expeditiously as possible. In building and improving a new or existing Tribal Social Services Program, the goal of permanency should become the focus and services should receive priority based on their effectiveness in obtaining permanency for children.

B. Tribal identity. The goal of permanency needs to be achieved in the context of maintaining and supporting the Indian child's sense of identity and community with his family, extended family and tribe.

Caution: There may be children in existing placements who have never developed a sense of Indian and tribal identity. Planning for these children must be done very carefully with the realization that for some the opportunity to return to the tribe will need to consider the child's feelings about his identity and his choice in re-involving himself with Indian culture.

Assessment and Evaluation.

The assessment and evaluation of the child, parents, extended family, and significant others should be competed as the basis of any placement decision. The points under each assessment are areas to be considered in every proposed placement but cannot be viewed as a complete assessment tool.

A. Assessment of Child: Areas to be Included.

1. Assessment and evaluation of the actual developmental and psychological stage of the child's behavior and feelings, taking into consideration the child's chronological age and emotional age.

2. The quality of the child's attachment to present foster parent(s).

3. The number of placements, duration of those placements, and the effect of those placements on the child.

4. The number of visits and quality of contact the child has had with parents and extended family.

5. An assessment of the agency's ability to arrange visits and support the relationship between the child and parent(s).

6. Identification of any specialized services the child is receiving (educational, social, medical, etc.)

7. Determination of the child's desires, wishes, and motivation to return to the reservation, given the age of the child and the situation.

8. Determination of who can meet the child's developmental needs regarding identity formation and development of tribal survival skills and self-esteem.

9. Discussion of the importance of the family, clan, and tribal support network for the child in terms of transmitting tribal and cultural values, attitudes, and coping mechanisms related to racial prejudice, peer acceptance, and dating and marriage practices.

B. Assessment of Parent(s) and Extended Family: Areas to be Considered.

1. Description of the social and developmental background and current information (i.e., age, tribal identification, marital situation and stability, present family responsibilities, areas of change and coping abilities.)

2. Discussion of the parent's attitudes and feelings about willingness and readiness to accept and cope with the returning child who has been in placement.

3. Discussion of the extent to which the extended family and community will accept and support the child's return and re-entry into the family and community.

4. Discussion of the extent to which the tribe will accept and support the child in terms of:
   a. Enrollment issues
   b. Supportive services such as counselling, funding for special needs and crisis intervention
   c. Acceptance of the child's differences
      (1) inability to speak tribal language
      (2) child who looks different, has different mannerisms, interests, hobbies, and overall frame of reference.

5. Evaluation of the family's ability to help the child negotiate differences in lifestyles:
   a. Different degrees of privacy
   b. Different degrees of physical closeness and ways of expressing affection (to touch or not to touch)
   c. Different hobbies and interests
   d. Child's familiarity with urban, materialistic values which may differ from family's values.

6. Identification of differences in religious and philosophical beliefs and practices.

7. Indication of the family's ability to utilize help in preparation for the child's re-entry into the family/extended family/tribe.

8. Indication of the ability and willingness of the siblings to adjust to the child's return.

9. Description of the extent to which the family's behavior has expressed an interest in having the childs returned to the home. Identify specific behaviours that indicate this.

C. Assessment of the emotional relationship between each of the persons involved (child, parent(s), foster parent(s), extended family).

1. The emotional attachments and bonds between the child, parent(s), foster parent(s), and extended family need to be described.

Points to consider:

a. If a natural parent has not had access to the child because of geographical distance, grounds for further lack of meaningful contact and relationship building between the parent and child do not exist. All efforts should be made to familiarize the child and parent with one another.

b. Children can be cared for emotionally by more than one person. Loyalty issues are based on property and ownership concepts. Indian values are based on sharing, cooperation, and group caring, not on individual vs. individual concepts. Indian child welfare services are to be based on Indian values and practices, not on concepts developed from a non-Indian world view.

c. Indian values and attitudes are practical and are based on common sense. The practice of having many persons available to care for the child is valued. The concept of "open adoption" has been a tradition long-practiced by Indian persons.

d. Placement decisions should incorporate the strengths and positiveness of each of the relatives in the child's past and current situations.

e. Children need to acknowledge their history and past relationships and be open to both sides of the family. They can have on-going positive emotional relationships with several significant persons.

f. The terms, "best interest of child" and "psychological parent" are often misused in planning for Indian children. (Destruction of American Indian Families, p.57).

2. The benefits of returning a child to his/her tribe should be considered:

Points to consider:

a. A chance to belong to an extended family and clan
   (1) develop a positive Indian identification
   (2) experience security
   (3) exposure to new identification models
   (4) learn tribal language

b. Importance of living on and becoming familiar

with reservation
   (1) learn traditional activities
   (2) learn an appreciation for spiritualism/land resources instead of material/consumerism.

c. Develop a world view incorporating spiritual/religious dimensions
   (1) social/religious ceremonies, pow-wows, intertribal rodeos
   (2) birth, naming, puberty rites
   (3) men's activities, i.e., sweat baths.

d. Experience the strengths of extended family
   (1) planning and decision-making involving more than one person
   (2) shared roles and responsibilities
   (3) integration of young and old
   (4) different child-rearing and discipline patterns.

e. The practice and knowledge of these various benefits will be influenced by
   (1) tribal background
   (2) intertribal marriage
   (3) degree of contact to non-Indian lifestyle
   (4) degree of economic and class variations experienced.

Alternative Placement Arrangements.

A. Thoughtful and sensitive planning and decision-making regarding child placement may include these factors:

1. Evaluation of the quality of the existing relationship within the family and the realistic options, given the current situation.

2. Determination of the future developmental tasks to be completed by the child. Who can help the child with these tasks? Identity issues and teaching of survival skills may be best handled by the on-reservation Indian family and community.

3. Acknowledgement of the child's own thoughts, desires and wishes.

4. Willingness of tribal and community services to make replacement workable for all involved.

5. Can the child, parent, and tribe be open, flexible and creative to new ideas and solutions that will make the placement successful for all involved?

6. Can the legal jurisdiction framework allow the child and parent(s) to maintain contact without physical transfer of custody?

7. Can funding from the tribe be included for children remaining in the previous home setting?

8. Can the tribe recruit and train a pool of on-reservation Indian families as a resource for older/special needs children when the natural family cannot care for the child?

B. The following chart of types of placements can be used to determine what placement best fits a particular child's needs based on the previous assessments:

PLACEMENT ALTERNATIVES

1. Return Child to Parent	Factors to be considered
a. Return child to parent(s) with no contact to past placement.	a. The appropriateness of this varies according to the individual situation. Having no contact between the child and his foster family denies the child child's chistory and is generally not a positive experience for either the child, parent(s), or foster parent(s).
b. Return child to parent(s) with decreasing contact between child and foster family.	This type of placement is usually healthy and promotes gradual acceptance idnetification and transfer of attachment of child from foster to biological family.
c. Return child to parent(s) with continuing contact with foster family.	This is known as an "open placement" and can be experienced as positive and healthy for all involved. This allows the child to have low significant, supportive families. The foster family may become similiar to an extended family. Both families must be compatible and committed to providing support for the child.
2. Leave Child with Foster Parents	
a. Child remains in foster home with no contact with family	This is rarely, if ever, appropriate. It should not be encouraged except for short period of time while some type of permanency planning takes place for the child. Without adequate review, the child may become "lost" in the system.
b. Child remains in foster home with some contact with family.	This is generally used for a limited time. Visits between bio-parent and child are maintained. This is sometimes necessary while child receives special services not obtainable at home (educational, medical, therapeutic foster care).
c. Child remains in off-reservation foster home and has some contact with family and other Indian persons in the community.	This is sometimes recommended for older children when for some reason the gap between the resources of the parent(s) to care for the child and the needs of the child prevent the child from living at home.

3. Place Child on Reservation with Extended Family or Foster Parents

a. Child placed from foster home into extended family with some on-going contact with parents.	Rearing of children by extended family members is a common Indian practice. The extended family needs to be evaluated regarding their desires, abilities and capacity to care for another child. The relationship between the child's parent and extended family should be evaluated as well. For the placement to be beneficial to the child an element of mutuality, acceptance, and support must be present between the parent(s) and the extended family.
b. Child placed with an Indian Foster family on reservation and has some contact with parent(s) and extended family. Tribe offers support for this when tried.	This is almost always appropriate for new placements. Careful diagnosis should be made before this kind of arrangement is used as a transitional home between off-reservation foster home and parent(s), as it may be more damaging to move the child an extra time than to leave him/her in the off-reservation foster home while the family is being prepared for the child's return.

4. Adoption

a. Adoption by extended family, other tribal member of Indian parents of a different tribe (order of preference dictated by ICWA, Sec. 105.(a).)	This is a preferred way of achieving permanency and strengthening the child's development of Indian identity a when a child's parent(s) are not able to provide a permanent home for the child. The concept of "open adoption" may be appropriately applied in those instances where some relationship with the parent(s) is possible and desirable, but full-time care of the child is not possible.
b. Adoption by foster parent if foster parent is not a member of the extended family, tribe or other Indian tribe.	This may be appropriate if, after careful assessment, it is determined that the child's parents cannot provide a permanent home, and replacement of the child would be damaging to him/her, and the foster parents are fully committed to providing a permanent adoptive home for the child.

5. Other Options

a. Child placed with foster parent(s) of another tribe.	This may be appropriate when child is in an urban area and the plan is to remain there. Permanency planning should be carefully implemented to avoid lengthy foster care placements.

MINNESOTA INDIAN WOMEN'S RESOURCE CENTER'S CHILDCARE PROGRAM

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MINNESOTA INDIAN WOMEN'S RESOURCE CENTER'S CHILDCARE PROGRAM

Phyllis White Shield Gough

The Minnesota Indian Women's Resource Center's Childcare Program, began operations in November of 1985 which provides daily childcare services for clients attending therapeutic activities at the Minnesota Indian Women's Resource Center (MIWRC). The MIWRC Childcare Program was a model program for developmentally delayed Indian children and their parents. Its goal was to increase family self sufficiency through education for parents and by working with their preschool age children in the home setting.

The MIWRC Childcare Program continues as a culturally-sensitive model program for developmentally delayed children and their parents. The childcare program is a service to vest parents with the skill and abilities necessary for them to assume a central role in the development of their children through nurturing and non-punitive parenting methods as prevention of child abuse and neglect and early childhood deprivation. The MIWRC Childcare Program is unique in its service delivery. It is the only culturally-sensitive program modeled for Indian women clients and their preschool children in Minnesota.

The MIWRC Childcare Program serves Indian children under the age of six (6) while their mothers are involved in intensive therapeutic treatment. Most of the children are of preschool age with a large percentage being infant and toddlers (birth to 2 years).

In our experiences of serving preschool children while mothers are receiving treatment, the children demonstrated a need to understand the changes that were occurring in their young lives as mothers are beginning a life of sobriety. Through our observations and directed childcare services to Indian children, we realized that the harmful effects of chemical dependency are not limited to adults.

The social development and mental health of the Indian preschool child often ranges from one extreme to another. As members of a chemically dependent home situation, their home environment often includes family alcohol and drug abuse. Young children are sometimes forced to assume parental roles and responsibilities and serve as "little parents" to younger siblings. Many preschool children also have experienced the trauma of out-of-home placement. These preschool children are often quite mature for their ages in the areas of "survival life experiences".

Based on these experiences and observations, MIWRC has successfully developed "Young Child, Old Spirit", a culturally-relevant chemically dependency, preschool curriculum is cooperative project between MIWRC and the Red Lake Alcohol Rehabilitation Center. This curriculum aims to help preschool children cope with the emotional and behavioral instability and family role confusion prevalent in chemical dependant home situations.

The "Our Sacred Gifts" curriculum provides visual material with very little written context to promote a cultural awareness of child-rearing techniques and empowering parents with knowledge in raising well developed children. The target audience for this curriculum is parents or primary caregivers whose reading skills are limited or who do not use reading as a primary source of information. The goal of this curriculum is to enhance the social, emotional, physical, cognitive, and moral development of children before conception and between conception and age three (3).

The "Our Sacred Gifts" curriculum consist of four "flip chart" calendars presenting an Ojibwe perspective on parenthood, embryo and fetal, infancy, and toddlerhood.

These culturally sensitive curriculums emphasize sobriety, Ojibwe cultural beliefs and practices, and the "healthy" development of Indian children. As young children, we form the habits that help shape our lives. Habits that have helped our people in the past to survive over the generations have become a valued part of our cultural traditions. We carry our habits with us throughout our lives. When we remember our cultural traditions, they can help to carry us through our every day situations. They can help us provide a healthy future for ourselves and

our people. For traditional Indian People, concern for past traditions and for the future generations were always of greater importance then the mere present moment.

Indian people today, do not live in the past but observe past traditions an invest these traditions in our children. Remembering what has happened in the past and remembering to think about the future of our people is the Indian way.

Habits of chemical abuse lock us in the need to feel good at the present moment. They make us forget about both the past and the future. They isolate us from member of our family and cut us off from who we really are. The physical, emotional, psychological, and social effects of chemical dependency, however, are not limited to the adult abusers. The children of chemically dependent parents suffer not only the physical effects of substance abuse, but also suffer from a devalued self-esteem and a confusion about their roles in the family system.

In the treatment of alcoholism and addiction, we often focus on the adult. We need to remember that young preschool children do not necessarily need treatment but prevention. Children living in homes where there is chemical abuse often become "forgotten victims". We need to help the children develop skills and habits that will help them to live healthy lives. ("Young Child, Old Spirit" curriculum, 1990 copyright).

"One of the biggest myths about families living with chemical abuse is that once a parent stops drinking, the child(ren) will automatically recover. Children need help on their own to deal with the dysfunctional behavior patterns that have already developed. No child can live in a chemically abusive environment for any length of time and remain not harmed. These children are raised in disrupted families characterized by more parental arguments, unpredictability, and physical or sexual abuse than is typical of healthy families". (Black, Bucky and Wilder - Padilla, 1986).

Drawing by Robert DesJarlait
Red Lake Band of Ojibwe

YOUNG CHILD, OLD SPIRIT

» PRESCHOOL CHEMICAL DEPENDENCY CURRICULUM «

"In many cultures, young children are considered sacred gifts to the family and the tribe . . .
Each child is to be treated with personal respect as an individual bearing special traits . . .
Each adult generation is to acknowledge the sacredness of young children and to care for the coming generation . . . "

Wahacanka Ska Win
Phyllis White Shield Gough

1990

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THE "OUR SACRED GIFTS" CURRICULUM HELPS REAFFIRM
AN OJIBWE PERSPECTIVE ON RESPONSIBILITY BEFORE
PREGNANCY AND PREPARATION FOR PARENTHOOD.
BOTH THE OJIBWE WOMAN AND MAN SHARE RESPONSIBILITIES
OF PREGNANCY AND DREAMS FOR THE CHILD.

Artist, Robert DesJarlait

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IT IS BELIEVED THAT WHEN AN INDIAN WOMAN IS PREGNANT, HER HUSBAND IS ALSO PREGNANT. THE SPECIAL PRECAUTIONS FOR PHYSICAL AND MENTAL HEALTH OBSERVED BY A PREGNANT WOMAN ARE TO BE OBSERVED BY THE FATHER AS WELL. MANY SUCH TRADITIONAL INDIAN BELIEFS ARE STILL PRACTICED TODAY. THE "OUR SACRED GIFTS" CURRICULUM HELPS REAFFIRM AN OJIBWE PERSPECTIVE ON EMBRYO AND FETAL DEVELOPMENT AND THE RESPONSIBILITY FOR PREGNANCY.

Artist, Robert DesJarlait

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ORGANIZATION OF INDIAN FAMILY PRESERVATION IN MINNESOTA

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ORGANIZATION OF INDIAN FAMILY PRESERVATION IN MINNESOTA

Loa Porter
Victoria Iron Graves

Presentation on Minnesota Indian Family Preservation in Minnesota

Theme:

The workshop will be presented in a three part series. Each series will be twenty-five minutes with the emphasis at the end of question and answer and drawing ideas.

PART ONE: (Length 25 minutes)

Minnesota Indian Family Preservation Act: This piece of legislation was passed in 1985 after the Indian Child Welfare Act had no impact on Minnesota in a fashionable manner. Many of the service providers were finding that notification of Indian children in out-of-home placement was not happening. Minnesota was among the states that still had a disproportionate rate of Indian children in foster care.

Tribes in Minnesota had not addressed these critical issues of placement planning, reasonable efforts and transfer of jurisdiction of cases.

A history of the Family Preservation Act will be reviewed. The first round of legislation lost in 1984 as there was not a popular belief that the issue of Indian children was a priority.

After the legislation was past, there were major impacts on the State of Minnesota. The presenters will review the impacts of the Preservation Act which will include:

1. Notification of Indian children being placed in foster care or other out-of-home placements became a state law.

2. Tribal governments had some means to receiving notifications.

3. Indian children and their families became a priority for some county casework.

4. Planning began to seek funding for carrying out the Preservation Act.

The workshop will address the historic funding cycle of Tribal Social Service delivery systems and what planning went into seeking funding for continuation of services.

There will be an overview of funding to tribal systems and the impact of Preservation Act on Tribal Systems. The Indian Emergency Relief Act was a lot of funding that had been set aside by counties. This was explored as to the impact and distribution of this funding source. It was found that Indian people did not and were not able to utilize this account. This became the funding source to begin Tribal Social Services. The workshop will discuss how this source of income became a reality without being a loss in other areas.

PART TWO: Organization of Tribal Social Services on the Reservations and the Use of Existing Urban Organizations.

In the organization of Tribal Social Services, many tribes had their ideas of what issues and concerns needed to be addressed. The funding system of Indian Child Welfare contracts and who would get what amount of dollars was a difficult process.

One of the most important factors of putting this together was the beginning of the Indian Child Welfare Task Force. Presenters will discuss the role of the Task Force in solidifying the contracts and setting in motion the process and objectives of the Indian Child Welfare Funds. In many states there have been attempts to unite the social service workers. The presenters will discuss the task force and how to develop this in different state environments.

The task force has become an advisory group in the last year of operation. There has been a number of areas of concern for the advisory group. There will be a discussion as to the meaning of the task force and how to move to the advisory group status.

PART THREE: Impacting on Problem Areas in the Indian Social Service Setting.

Presenters will identify several problem areas that Minnesota has and had in implementing the Family

Preservation Act as well as the Indian Child Welfare Act. There will also be the positive growth from the implementation of Tribal Social Services and Urban Organization that work in Child Welfare.

The negatives that were experienced included:

1. County social workers often times did not notify tribes or urban organizations when an Indian child went into placement.

2. County workers guarded their cases and were secretive in placement planning.

3. There were unreasonable expectations of Indian families in order to reunite the family.

4. Termination of parental rights was the answer to the parent not cooperating with social workers.

5. Reasonable efforts were not being made for reunification of the family.

6. Indian advocates were not seen as valuable to state court systems.

7. Indian culture and heritage were not viewed as valuable by social workers.

8. Family, extended family and tribal members were not sought as an alternative for long range permanency placement planning.

The Tribal Social Services System and Urban Organizations have impacted on the state in positives. Since the flow of funding is now with the Indian Organizations there have been changes such as:

1. Education of county workers in areas of Family Preservation, Indian Child Welfare, notification, reasonable efforts.

2. Assistance by Indian people in case management and long term planning.

3. Recognition of Indian advocates as useful in cases regarding out of home placement.

4. Programs on reservations that have a Family Based or Homebased technique of healing families who have been labeled dysfunctional.

The Indian Child Welfare Advisory Council formed a subcommittee to compile and document the caseloads and program work done by Tribal Social Services and Urban Indian Programs.

The presenters will go through some of the major issues of Indian child welfare delivery services, problems and resolutions.

There will be a discussion on the differences between the Public Law 280 states and the reservations with Tribal Court Systems.

We will do a brief survey of the reservation areas and how to set up task forces to begin the process of unity of human services.

The transfer of jurisdiction to PL 280 states created serious financial problems for the states and/or counties involved. Property taxes, usually the main source of taxes at the county level, are prohibited on Indian trust lands. Many states felt that federal funds should be allocated to support state-provided services to Indians, but such funds were not forthcoming. In the majority of cases the Federal Government did not cede jurisdiction to the states. The many tribes in these non-PL 280 states had theoretical jurisdiction over such child welfare matters as foster care placement, adoptions and child abuse and neglect.

States are reluctant to accept tribal jurisdiction because:

-- In order to be eligible for federal reimbursements, aid to families with dependent children, foster care (AFDC-FC) homes and day-care facilities must be licensed or approved.

-- State governments have been reluctant to contract with tribal governments for the provision of services because they lack the power to take tribal governments to court to recover funds which might be spent outside the terms of a contract or without proper documentation (ICW:5).

-- Where Title II is involved, states are reluctant to pay the 25% local share necessary to earn the 75% federal share.

- State governments do not have the power to tax Indians' real or personal property on reservations, nor can states tax Indians' income earned on reservations. Accordingly, states have often argued that they cannot afford to pay the local share for services to reservation Indians (ICW:5).

- This attitude should be contrasted with the stated legal responsibility to tribes (or segments thereof) within their borders. Indians are citizens of the state in which they reside and are entitled to share in its benefits.

- In PL 280 states, reservations reassuming jurisdiction of Indian child custody proceedings must petition the Bureau of Indian Affairs.

The Secretary of the Interior will use a number of criteria for evaluating the petitions for reassumption of jurisdiction; among them are:

- A tribal judicial system has been established that is capable of adjudicating child custody matters in a manner that meets the requirements of the Indian Civil Rights Act, 25 U.S.C. E1 SEQ;

- child care services sufficient to meet the needs of any child that the tribal system finds must be removed from parental custody are available; and

- the tribe or tribes have established a procedure for clearly identifying who is a member of the tribe or is eligible for membership.

The petition procedures make a number of assumptions about tribal and Indian organizations' capacities to assemble and provide information and child welfare services, including a prior capacity to provide a census data about the tribe, an existing judicial system with a juvenile code formulated to meet the needs of American Indians is in place, and that a coordinated child welfare delivery system exists prior to resumption of jurisdiction.

Many tribes and Indian organizations lack the resources to meet the petitioning criteria. Therefore, technical assistance prior to the petition procedure is necessary.

Licensing of child placement agency services and child care have been a major goal of Indian tribes and Indian child welfare agencies. Yet states have been reluctant to provide this recognition, citing several reasons for their reluctance to license tribal services on reservations which include that states do not have the power to enforce licensing procedures on non-PL 280 reservations and licensing and recruiting standards for foster homes generally have not been spelled out and are still a problem because of differing cultural standards.

The Indian Child Welfare Act has somewhat changed these circumstances with respect to federal funding. Section 201(B) provides that "licensing or approval of foster or adoptive homes or institutions by an Indian tribe is deemed equivalent to state licensing or approval for purposes of qualifying for assistance under a federally assisted program."

The major drawback of the Indian Child Welfare Act was the lack of funding to implement it. Only in early 1980 were the first funds made available (through the Bureau of Indian Affairs) for small mini-grants to develop pilot projects addressing the issues raised in the Indian Child Welfare Act.

1980 and 1981 will be pivotal years. The reclaiming of our children, the undergirding of our families, has to be our highest priority. Any assistance we can provide in that direction will be heartily undertaken.

National Indian Child Abuse & Neglect Resource Center; Tulsa, Oklahoma.

MIFPA
(Minnesota Indian Family Preservation Act)

AN ACT

CHAPTER No 111

Distributed By
Secretary of the SENATE
Room 231, State Capitol
St. Paul, 296-2343

relating to human services; providing for participation by Indian tribes in the placement of their children; proposing coding for new law in Minnesota Statutes, chapter 257.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [257.35] [CITATION.]

Sections 1 to 8 may be cited as the "Minnesota Indian family preservation act."

Sec. 2. [257.351] [DEFINITIONS.]

Subdivision 1. [SCOPE.] As used in sections 1 to 8, the following terms have the meanings given them.

Subd. 2. [ADMINISTRATIVE REVIEW.] "Administrative review" means review under Minnesota Statutes, section 257.071.

Subd. 3. [CHILD PLACEMENT PROCEEDING.] "Child placement proceeding" includes a judicial proceeding which could result in the following:

(a) "Adoptive placement" means the permanent placement of an Indian child for adoption, including an action resulting in a final decree of adoption.

(b) "Involuntary foster care placement" means an action removing an Indian child from his or her parents or Indian custodian for temporary placement in a foster home, institution, or the home of a guardian. The parent or Indian custodian

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cannot have the child returned upon demand, but parental rights have not been terminated.

(c) "Preadoptive placement" means the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, before or instead of adoptive placement.

(d) "Termination of parental rights" means an action resulting in the termination of the parent-child relationship under Minnesota Statutes, section 260.221.

The terms include placements based upon juvenile status offenses, but do not include a placement based upon an act which if committed by an adult would be deemed a crime, or upon an award of custody in a divorce proceeding to one of the parents.

Subd. 4. [DEMAND.] "Demand" means a written and notarized statement signed by a parent or Indian custodian of a child which requests the return of the child who has been voluntarily placed in foster care.

Subd. 5. [INDIAN.] "Indian" means a person who is a member of an Indian tribe or an Alaskan native and a member of a regional corporation as defined in section 7 of the Alaska Native Claims Settlement Act, United States Code, title 43, section 1606.

Subd. 6. [INDIAN CHILD.] "Indian child" means an unmarried person who is under age 18 and is:

(1) a member of an Indian tribe; or

(2) eligible for membership in an Indian tribe.

Subd. 7. [INDIAN CHILD'S TRIBE.] "Indian child's tribe" means the Indian tribe in which an Indian child is a member or eligible for membership. In the case of an Indian child who is a member of or eligible for membership in more than one tribe, the Indian child's tribe is the tribe with which the Indian child has the most significant contacts. If that tribe does not express an interest in the outcome of the actions taken under sections 1 to 8 with respect to the child, any other tribe in which the child is eligible for membership that expresses an interest in the outcome may act as the Indian child's tribe.

Subd. 8. [INDIAN CUSTODIAN.] "Indian custodian" means an Indian person who has legal custody of an Indian child under tribal law or custom or under state law, or to whom temporary physical care, custody, and control has been transferred by the parent of the child.

Subd. 9. [INDIAN TRIBE.] "Indian tribe" means an Indian tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the secretary because of their status as Indians, including any band under the Alaska Native Claims Settlement Act, United States Code, title 43, section 1602, and exercising tribal governmental powers.

Subd. 10. [LOCAL SOCIAL SERVICE AGENCY.] "Local social service agency" means the local agency under the authority of the county welfare or human services board or county board of commissioners which is responsible for human services.

Subd. 11. [PARENT.] "Parent" means the biological parent of an Indian child, or any Indian person who has lawfully adopted an Indian child, including a person who has adopted a child by tribal law or custom. It does not include an unmarried father whose paternity has not been acknowledged or established.

Subd. 12. [PRIVATE CHILD PLACING AGENCY.] "Private child placing agency" means a private organization, association, or corporation providing assistance to children and parents in their own homes and placing children in foster care or for adoption.

Subd. 13. [RESERVATION.] "Reservation" means Indian country as defined in United States Code, title 18, section 1151 and any lands which are either held by the United States in trust for the benefit of an Indian tribe or individual, or held by an Indian tribe or individual subject to a restriction by the United States against alienation.

Subd. 14. [SECRETARY.] "Secretary" means the secretary of the United States department of the interior.

Subd. 15. [TRIBAL COURT.] "Tribal court" means a court with jurisdiction over child custody proceedings which is either

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a court of Indian offenses, or a court established and operated under the code or custom of an Indian tribe, or the administrative body of a tribe which is vested with authority over child custody proceedings.

Subd. 16. [TRIBAL SOCIAL SERVICE AGENCY.] "Tribal social service agency" means the unit under authority of the governing body of the Indian tribe which is responsible for human services.

Subd. 17. [VOLUNTARY FOSTER CARE PLACEMENT.] "Voluntary foster care placement" means a decision in which there has been participation by a local social service agency or private child placing agency resulting in the temporary placement of an Indian child away from the home of his or her parents or Indian custodian in a foster home, institution, or the home of a guardian, and the parent or Indian custodian may have the child returned upon demand.

Sec. 3. [257.352] [SOCIAL SERVICE AGENCY AND PRIVATE LICENSED CHILD PLACING AGENCY NOTICE TO TRIBES.]

Subdivision 1. [DETERMINATION OF INDIAN CHILD'S TRIBE.] The local social service agency or private licensed child placing agency shall determine whether a child brought to its attention for the purposes described in this section is an Indian child and the identity of the Indian child's tribe.

Subd. 2. [AGENCY NOTICE OF POTENTIAL OUT-OF-HOME PLACEMENT.] When a local social service agency or private child placing agency determines that an Indian child is in a dependent or other condition that could lead to an out-of-home placement and requires the continued involvement of the agency with the child for a period in excess of 30 days, the agency shall send notice of the condition and of the initial steps taken to remedy it to the Indian child's tribal social service agency within seven days of the determination. At this and any subsequent stage of its involvement with an Indian child, the agency shall, upon request, give the tribal social service agency full cooperation including access to all files concerning the child. If the files contain confidential or private data, the agency may require execution of an agreement with the tribal social

service agency that the tribal social service agency shall maintain the data according to statutory provisions applicable to the data.

Subd. 3. [PRIVATE CHILD PLACING AGENCY NOTICE OF POTENTIAL PREADOPTIVE OR ADOPTIVE PLACEMENT.] When a private child placing agency determines that an Indian child is in a dependent or other condition that could lead to a preadoptive or adoptive placement, the agency shall send notice of the condition to the Indian child's tribal social service agency within seven days of the determination. The agency shall include in the notice the identity of the birthparents and child absent written objection by the birthparents. The private child placing agency shall inform the birthparents of the Indian child of any services available to the Indian child through the child's tribal social service agency, including child placement services, and shall additionally provide the birthparents of the Indian child with all information sent from the tribal social service agency in response to the notice.

Subd. 4. [IDENTIFICATION OF EXTENDED FAMILY MEMBERS.] Any agency considering placement of an Indian child shall make reasonable efforts to identify and locate extended family members.

Sec. 4. [257.353] [VOLUNTARY FOSTER CARE PLACEMENT.]

Subdivision 1. [DETERMINATION OF INDIAN CHILD'S TRIBE.] The local social service agency or private licensed child placing agency shall determine whether a child brought to its attention for the purposes described in this section is an Indian child and the identity of the Indian child's tribe.

Subd. 2. [NOTICE.] When an Indian child is voluntarily placed in foster care, the local social service agency involved in the decision to place the child shall give notice of the placement to the child's parents, tribal social service agency, and the Indian custodian within seven days of placement, excluding weekends and holidays.

If a private licensed child placing agency makes a temporary voluntary foster care placement pending a decision on

adoption by a parent, notice of the placement shall be given to the child's parents, tribal social service agency, and the Indian custodian upon the filing of a petition for termination of parental rights or three months following the temporary placement, whichever occurs first.

At this and any subsequent stage of its involvement with an Indian child, the agency shall, upon request, give the tribal social service agency full cooperation including access to all files concerning the child. If the files contain confidential or private data, the agency may require execution of an agreement with the tribal social service agency that the tribal social service agency shall maintain the data according to statutory provisions applicable to the data.

Subd. 3. [NOTICE OF ADMINISTRATIVE REVIEW.] In an administrative review of a voluntary foster care placement, the tribal social service agency of the child, the Indian custodian, and the parents of the child shall have notice and a right of participation in the review.

Subd. 4. [RETURN OF CHILD IN VOLUNTARY PLACEMENT.] Upon demand by the parent or Indian custodian of an Indian child, the local social service agency or private licensed child placing agency shall return the child in voluntary foster care placement to the parent or Indian custodian within 24 hours of the receipt of the demand. If the request for return does not satisfy the requirement of section 7, subdivision 4, the local social service agency or private child placing agency shall immediately inform the parent or Indian custodian of the Indian child of the requirement.

Subd. 5. [IDENTIFICATION OF EXTENDED FAMILY MEMBERS.] Any agency considering placement of an Indian child shall make reasonable efforts to identify and locate extended family members.

Sec. 5. [257.354] [CHILD PLACEMENT PROCEEDINGS.]

Subdivision 1. [INDIAN TRIBE JURISDICTION.] An Indian tribe with a tribal court has exclusive jurisdiction over a child placement proceeding involving an Indian child who resides

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within the reservation of such tribe at the commencement of the proceedings. When an Indian child is in the legal custody of a person or agency pursuant to an order of a tribal court, the Indian tribe retains exclusive jurisdiction, notwithstanding the residence or domicile of the child.

Subd. 2. [COURT DETERMINATION OF TRIBAL AFFILIATION OF CHILD.] In any child placement proceeding, the court shall establish whether an Indian child is involved and the identity of the Indian child's tribe.

Subd. 3. [TRANSFER OF PROCEEDINGS.] In a proceeding for the termination of parental rights or involuntary foster care placement of an Indian child not within the jurisdiction of subdivision 1, the court, in the absence of good cause to the contrary, shall transfer the proceeding to the jurisdiction of the tribe absent objection by either parent, upon the petition of either parent or the Indian custodian or the Indian child's tribe. The transfer shall be subject to declination by the tribal court of such tribe.

Subd. 4. [EFFECT OF TRIBAL COURT PLACEMENT ORDERS.] To the extent that any child subject to sections 1 to 8 is otherwise eligible for social services, orders of a tribal court concerning placement of such child shall have the same force and effect as orders of a court of this state. In any case where the tribal court orders placement through a local social service agency, the court shall provide to the local agency notice and an opportunity to be heard regarding the placement. Financial responsibility for the placement shall be determined by the local social service agency and shall be subject to review by the commissioner in accordance with sections 14.01 to 14.69.

Sec. 6. [257.355] [PLACEMENT RECORDS.]

The commissioner of human services shall publish annually an inventory of all Indian children in residential facilities. The inventory shall include, by county and statewide, information on legal status, living arrangement, age, sex, tribe in which the child is a member or eligible for membership, accumulated length of time in foster care, and other demographic

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information deemed appropriate concerning all Indian children in residential facilities. The report must also state the extent to which authorized child placing agencies comply with the order of preference described in United States Code, title 25, section 1911, et seq.

Sec. 7. [257.356] [RECORDS; INFORMATION AVAILABILITY.]

Subdivision 1. [COURT DECREE INFORMATION.] A state court entering a final decree or order in an Indian child adoptive placement shall provide the department of human services and the child's tribal social service agency with a copy of the decree or order together with such other information to show:

(1) the name and tribal affiliation of the child;

(2) the names and addresses of the biological parents;

(3) the names and addresses of the adoptive parents; and

(4) the identity of any agency having files or information relating to the adoptive placement.

If the court records contain an affidavit of the biological or adoptive parent or parents requesting anonymity, the court shall delete the name and address of the biological or adoptive parents from the information sent to the child's tribal social service agency.

Subd. 2. [DISCLOSURE OF RECORDS.] Upon the request of an adopted Indian person over the age of 18, the adoptive or foster parents of an Indian person, or an Indian tribal social service agency, the department of human services shall disclose to the Indian person's tribe information necessary for membership of an Indian person in the tribe in which the person may be eligible for membership or for determining any rights or benefits associated with that membership. When the documents relating to the person contain an affidavit from the biological or adoptive parent or parents requesting anonymity, the department must use the procedures described in United States Code, title 25, section 1951, paragraph (b).

Sec. 8. [257.357] [RULE CHANGE.]

The commissioner of human services shall amend Minnesota Rules, parts 9545.0710 and 9545.0790, to provide that an agency

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that places Indian children shall cooperate with the Indian child's tribe in securing placement that is consistent with the child's racial or ethnic heritage, as indicated by the policy statements in Minnesota Statutes, sections 259.255, and 259.29, subdivision 2. The amendment is not subject to the rulemaking provisions of chapter 14, but the commissioner must comply with section 14.38, subdivision 7, in adopting the amendment.

H. F. No. 782

David M. Jennings
Speaker of the House of Representatives

Jerome M. Hughes
President of the Senate

Passed the House of Representatives this 2nd day of May in the year of Our Lord one thousand nine hundred and eighty-five.

Edward A. Burdick
Chief Clerk, House of Representatives.

Passed the Senate this 6th day of May in the year of Our Lord one thousand nine hundred and eighty-five.

Patrick E. Flahaven
Secretary of the Senate.

Approved 5/10/85

Rudy Perpich
Governor of the State of Minnesota.

Filed 5/10/85

Joan Anderson Growe
Secretary of State.

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POST TRAUMATIC STRESS DISORDER

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POST-TRAUMATIC STRESS DISORDER

Jerry Northrup
Joe Potter

The return of our veterans from Vietnam in the middle 1970's served as the significant means for Post-Traumatic Stress being diagnosed as a disorder. Before the Vietnam war, the terms most often used to describe the state were shell-shocked or battle fatigue. Post-Traumatic Stress Disorder has since been expanded in application not only to include our veterans returning from war but also to include any one suffering from the experience of a serious traumatic event. The trauma may be experienced alone or in the company of groups of people.

Stressors producing this disorder include: natural disasters (e.g. flood, earthquakes), accidental disasters (e.g. car accidents with serious physical injury, airplane crashes, large fires, collapse of physical structures), or deliberately caused disasters, (e.g. bombing, torture, death camps). Some frequently produce the disorder (e.g. torture) and others produce it only occasionally (e.g. natural disasters or car accidents). The traumatic event can be re-experienced in a variety of ways: commonly, the person has recurrent and intrusive recollections of the event or recurrent distressing dreams during which the event is re-experienced. In rare instances, there are dissociative states, lasting from a few seconds to several hours, or even days, during which components of the event are relived, and the person behaves as though experiencing the event at the moment. There is often intense psychological distress when the person is exposed to events that resemble an aspect of the traumatic event or that symbolize the traumatic event, such as anniversaries of the event.

In addition to the re-experiencing of the trauma, there is persistent avoidance of stimuli associated with it, or a numbing of general responsiveness that was not present before the trauma. The person commonly makes deliberate efforts to avoid thoughts or feelings about the traumatic event and about activities or situations that arouse recollections of it. This avoidance of reminders of the trauma may include the occurrence of psychogenic amnesia associated with an important aspect of the traumatic event. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed activities; or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased. Persistent symptoms of increased arousal that were not present before the trauma include: difficulty in falling asleep (recurrent nightmares during which the traumatic event is relived are some times accompanied by middle or terminal sleep disturbance), hypervigilance, and exaggerated startle response. Some complain of difficulty in concentrating or in completing tasks. Many report changes in aggression. In mild cases, this may take the form of irritability with fear of losing control. In more severe forms, particularly in cases in which the survivor has actually committed acts of violence, the fear is conscious and pervasive, and the reduced capacity for modulation may express itself in unpredictable explosions of aggressive behaviors or in an inability to express angry feelings.

Age-specific Features

Occasionally, a child may be mute or refuse to discuss the trauma, but this state should not be confused with the inability to remember what occurred. In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, or rescuing others, or of threats to self or others. Young children do not have the sense that they are reliving the past; reliving the trauma occurs in action, through repetitive play. Both diminished interest in significant activities and construction of affect may be difficult for children themselves to report; they should be carefully evaluated in reports from parents, teachers, and other observers. A symptom of Post-Traumatic Stress Disorder in children may be a marked change in orientation toward the future, which includes the sense of a foreshortened

future, e.g., a child may not expect to experience a career or marriage. There may also be "omen formation" or the belief in the ability to prophesy future untoward events. In addition, children may exhibit various physical symptoms, such as stomachaches and headaches.

Associated Features

Symptoms of depression and anxiety commonly occur and, in some instances, may be sufficiently severe to be diagnosed as an anxiety or depressive disorder. Impulsive behaviors can occur, such as suddenly changing place of residence, unexplained absences, or other changes in lifestyle. Additionally, there may be symptoms of an organic mental disorder, such as failing memory, difficulty in concentrating, emotional lability, headache, and vertigo. In the case of a life-threatening trauma, they need to share with others. Survivors often describe painful guilt feelings about surviving when others did not or about the things they had to do in order to survive.

Age At On-Set

The disorder can occur at any age, including during childhood.

Impairment and Complications

Impairment may be either mild or severe and affect nearly every aspect of life.[1]

History has taught us that, given enough stress, anyone can develop this syndrome.[2]

Survivors frequently describe periods of feeling "little", as the helpless emotions of childhood return.[3]

There is evidence that children are more vulnerable to less extreme ignore than those which may cause PTSD in adults.[4]

In 1874, Buck, a sled dog, was beaten by his owner. The owner was taken to court by the Society for the Prevention of Cruelty to Animals. At the same time, the Society argued that children deserved the same legal rights as the other animals. This story serves to remind us that child abuse is a relatively new concept.

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PRACTICAL CASE APPLICATION FOR TRIBAL COURT JUDGES DEVELOPING AND USING PROTOCOLS IN CHILD ABUSE & NEGLECT CROSS CULTURAL INTERVENTION IN CHILD ABUSE & NEGLECT

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Practical Case Applications for Tribal Judges

Tribal judges have and must operate within the context of a complex cultural society. This society, found within the boundaries of the reservation, and amidst great strife due to economics, addiction, can be such that judges are subject to great stress.

Judges often find themselves assigned a case that is not simple neglect but is one that involves the extended family, community, and agencies. These "players", complicate the case by pressuring the judge to find facts, based on the cultural norms, community sentiment, agency commitment, and personal feelings, rather than on what the law is and what the facts say the law must do. There are some practical considerations that judges can utilize in case management. These guides are offered as suggestions, and are not meant to be all inclusive.

1. DEFINING THE CASE:

It is important for judges to be able to discern the type of action filed. Some abuse and neglect cases are brought into court in the form of a petition. This process is dictated by the tribal code. As a matter of reference, if the petition is incomplete or vague, it is open to dismissal. This challenge can be brought by the respondent, or in the absence of an advocate, the judge can review and question the petitioner about the petition before deciding if the case should proceed.

Most tribal codes have been revised in the area of children and families to address, more clearly, the process in bringing a case of abuse or neglect. Most codes are specific about what is required in the statement that sets forth the facts.

2. INDIAN CIVIL RIGHTS ACTS

The 1968 Act requires that tribal courts afford due process and equal protection to all persons appearing before the court. In an abuse or neglect action, these provisions apply and must be documented.

due process is basic notice, hearing, & opportunity to be heard. Judges should carefully examine the record for this provision before proceeding. A basic and frequent complaint about tribal courts is that due process is lacking. Tribal members should believe that the court is fair, impartial and conscious of their rights.

Equal protection means that the court must process a case in a manner that is fair, impartial, and the same as all other cases. The Indian Civil Rights Act applies to both Indian and non-Indian litigants. tribal courts cannot operate a double standard in applying justice. In abuse and neglect actions, the judge is responsible for monitoring the rights of the parties and for correcting any errors. An example would be where a hearing was set on a petition filed to remove three children from the natural parents. The parents were called on the phone or stopped in the store and told about the hearing. Both parents are chronic alcoholics. The day of court neither parent showed. The juvenile officer informed the court that he/she called the parents. The judge accepted this as "notice" and proceeded to grant the petition and remove the children. The following day, both parents arrive at court to question the process, claiming they did not receive formal, written notice. In this example, the court would have to address this claim and correct the situation by rescinding the removal order, returning the children, and possibly setting another hearing. All of this could have been avoided had the judge questioned the lack of written notice on the record.

Invariably, if a case gets to the appellate level, it would be on due process or equal protection grounds.

3. RISK ASSESSMENT

Most cases of abuse or neglect allege that the child or children are in danger. This may be true, however, the judge ultimately will have to decide if

ability of parent to protect the child. In Indian country we have to honor the extended family process. This process requires assuming responsibility for children at risk. The extended family can offer comfort and stability for a child subjected to the trauma of intervention. Most parents, who are accused of abuse or neglect, will cooperate more if the extended family is offered as an alternative to placement in a center. Judges are urged to consider drawing upon the extended family when assessing the amount of risk to the child. This appears to calm things down and be less traumatic to the child. The judge is also viewed in a more humane light - which in and of itself is a prime factor to assisting parents who abuse or neglect their children.

The opposite of removal is to allow the child to remain with parents inspite of court action. Tribal judges can expect that cooperating agencies will disagree in some cases. This factor is important but should not pressure the judge into making decisions that common sense says should not be made.

Judges can expect that a prime opportunity for intervention is before the court with some parents - especially if the decision is made to return the children. Some parents are willing to listen, take action, and to cooperate in order to keep their children. Judges can issue a "conditional" order returning the children until a hearing. This order can require certain things to be done such as an alcohol evaluation. In any event, reasons for determining risk should be set forth by the court and made part of the record.

4. POLICIES

In tribal communities it is exceedingly difficult for tribal judges to remain apolitical. Ethics require that all judges remain fair, impartial, and objective. In tribal communities, some tribal judges are viewed in a dim light if they spout ethics or make decisions that effect the community. This is part of the job and is not an easy lesson. Some tribal judges view their positions as unstable and subject to the daily politics drifting from the council and community. This factor alone can inhibit progress in a community plagued by a high incidence of neglect.

A suggestion would be to institute open communication ny the court with the council. This can bring about an opportunity to get commitments about a chain of command that stems directly from the personnel manual, ethics code, and departmental supervisors. If the tribe has a law & order committee, the court administrator or chief judge can initiate education that will show the committee how important it is to allow the court to be independent and safe from political interference. The only guarantee that the court will be absolved from accusations of impropriety is to build in the requirement that all court employees comply with a code of conduct or ethnics code. This alone is a stability factor within the system and a safeguard when politics began to creep into the system.

There are some tribal courts who enjoy a separation of powers. This is a good position for the court but it does not discount the fact that conduct and ethics of court employees are factors that allow politics to interfere with progress.

There are some councils that choose to take a judge or the court system to task in a particular case of abuse or neglect. This is initiated by the parties (usually the parents) and brought to the council meeting as an agenda item. If the court is called in to defend an action - it is always safe to invoke confidentiality because the case is in progress. The council can be formally asked not to proceed on the matter until the court is finished, and then, if necessary, review can be conducted by the council with the consent of all parties. An example is where you have a parent who is sexually abusing a child in the home. The matter is volatile from the beginning. As a matter of investigation, and with knowledge of the CPS, the child is removed until the investigation is complete or the preliminary hearing is held. Invariably some parents will run to the council and cry "foul". They will accuse the court of violating their rights, etc. They will <u>not</u> be up front with the council and discuss their guilt but will strongly assert their innocence (even with staggering evidence).

In some abuse or neglect cases you will have parents who tell the council that they do not know why their child was removed. As a matter of procedure, the council will call the chief judge or court administrator in to inquire about the case. This should trigger someone that the council is not thinking of the confidentiality factor. It would be appropriate to seek leave to address the council in a closed meeting only to state that the case is in progress and should be protected by the confidentiality code. In addition, it would also be appropriate to state that the Tribal Code and Indian

Civil Rights Act have been complied with because the parents have received notice of a hearing and that the court will protect their rights the same as any other person. This may work in some systems, depending on the political nature of the council persists and wants to address the issue, the court should stand firm on the case confidentiality. The worst scenario here is to be fired for not cooperating, and to send a message that it is okay for the council to interfere. If a judge is fired for standing on ethics, then there are clear grounds for a personnel grievance or wrongful discharge suit.

In any event, tribal court systems should learn the politics and in addition learn the advantages and disadvantages of working in a tribal system. I personally guarantee that it is experience unlike any other, professionally.

5. AGENCY COOPERATION & RESPONSIBILITY

Child abuse and neglect cases have a tendency to progress slowly, much to the detriment of the child and parents. Tribal courts can address this by working out protocol agreements with participating agencies. These agreement outline what is required in response to a case. If the court is experiencing a problem with case "backlog", then it would be wise to call a meeting to discuss problem areas. Communication, commitment, and caring are all factors that families should expect from participating agencies. This is ideal and not easily met due to several factors that contribute to breakdown in communication. Protocol agreements can help alleviate most problems in this area.

Developing And Using Protocols

Many inter-agency conflicts arise from confusion or disagreements over what actions are to be taken by each of the agencies involved with a particular clients or family.

Protocols are one method of preventing such conflicts. A protocol is a concise, written description (2-3 pages) of the steps to be taken by each agency in a situation that typically requires involvement of multiple professionals and multiple agencies.

The need for protocols is best illustrated in cases of child sexual abuse. Such cases typically involve the CPS agency, law enforcement, the prosecutor and professionals conducting special evaluations. These cases become more complex if some of the agencies are tribal and others are state or federal.

Much confusion and unnecessary conflict can be avoided if these agencies can agree to a plan that broadly outlines who will do what with whom, when, where, and in what sequence. Developing a protocol can be a demanding task by certain steps can facilitate the process. (The steps needed to work out a plan will be discussed in detail during the conference).

Cross Cultural Intervention In Child Abuse And Neglect

Under even benign conditions, cross-cultural intervention is complex. It is extraordinarily complex when intervention occurs with the child protection field in Indian Country. A CPS intervention takes place in a context of fear and anger and it focuses on highly personal and emotionally charged topics such as the parent's behavior, parent-child interaction, or family functioning. Consequently the potential for misunderstanding and misinterpretation is very great. Protocols are one approach to dealing with issues arising out of cross-cultural intervention in child abuse and neglect.

To minimize problems associated with cross-cultural CPS-related interaction, the CPS worker must be especially sensitive to cultural and community factors that usually impact on the Indian parent and help to explain the behaviors that, all to often, result in the Indian parent being labeled "resistant", "unmotivated", "uncooperative" or "hard to reach". These factors include poverty, racism and discrimination, incomplete grieving, the boarding school legacy, fear of foster care, effects of substance abuse, identity problems, power of extended family and the dynamics of the tribal community.

During this presentation, these and other factors will be discussed. In addition, the workshop will clarify the nature of cross-cultural interaction. The overall goal is to impress on the average non-Indian caseworker that intervention requires more than working knowledge of social work methods.

INDIAN CIVIL RIGHTS ACT OF 1968: 25 USC §1301 - §1303

§1301. Definitions For purposes of this subchapter, the term:

1. "Indian tribe" means any tribe, band, or other group of Indians subject to the jurisdiction of the United States and recognized as possessing powers of self-government.

2. "powers of self-government" means and includes all governmental powers possessed by an Indian tribe, executive, legislative, and judicial, and all offices, bodies, and tribunals by and through which they are executed, including courts of Indian offenses; and means the inherent power of Indian tribes, hereby recognized and affirmed, to exercise criminal jurisdiction over all Indians;

3. "Indian court" means any Indian tribal court or court of Indian offense, and

4. "Indian" means any person who would be subject to the jurisdiction of the United States as an Indian under section 1153, title 18, United States Code, if that person were to commit an offense listed in that section in Indian country to which that section applies."

§1302. Constitutional Rights No Indian tribe in exercising powers of self-government shall:

1. make or enforce any law prohibiting the free exercise of religion, or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble and to petition for a redress of grievances;

2. violate the right of the people to be secure in their persons, houses, papers, and effects against unreasonable search and seizures, nor issue warrants, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched and the person or thing to be seized;

3. subject any person for the same offense to be twice put in jeopardy;

4. compel any person in any criminal case to be a witness against himself;

5. take any property for a public use without just compensation;

6. deny to any person in a criminal proceeding the right to a speedy and public trial, to be informed of the nature and cause of the accusation, to be confronted with the witnesses against him, to have compulsory process for obtaining witnesses in his favor, and at his own expense to have the assistance of counsel for his defense;

7. require excessive bail, impose excessive fines, inflict cruel and unusual punishments, and in no event impose for conviction of any one offense any penalty or punishment greater than imprisonment for a term of one year or a fine of $5,000 or both;

8. deny to any person within its jurisdiction the equal protection of its laws or deprive any person of liberty or property without due process of law;

9. pass any bill of attainder or ex post facto law; or

10. deny to any person accused of an offense punishable by imprisonment the right, upon request, to a trial by jury of not less than six persons.

§1303. Habeas corpus The privilege of the writ of *habeas corpus* shall be available to any person, in a court of the United States, to test the legality of his detention by order of an Indian tribe.

Section 8070(d) The effects of subsections (b) and (c) [the underlined sections above] as those subsections affect the criminal misdemeanor jurisdiction of tribal courts over non-member Indians shall have no effect after September 30, 1991.

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POST TRAUMATIC CULTURAL DISORDER (PTCD) FUNCTIONAL & DYSFUNCTIONAL ALASKA NATIVE AMERICAN CODEPENDENCE (ENMESHED CODEPENDENCE)

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This paper is dedicated to the late
Luzenia Marotta
of the Chippewa Nation

POST TRAUMATIC CULTURAL DISORDER (PTCD)/FUNCTIONAL & DYSFUNCTIONAL ALASKA NATIVE AMERICAN CODEPENDENCE (ENMESHED CODEPENDENCE)

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John Baertschy
Luzenia Marotta
Hanah "Candy" O'Steen

INTRODUCTION

The Interior & Northern Regional Training Office, based at the Fairbanks Native Association in Fairbanks, Alaska, developed and field-tested a course titled PPC(293) CODEPENDENCY AN OVERVIEW AND ACOA WORKPLACE ISSUES, and to date, the course has been offered at: The North Slope Higher Education Center, Barrow, Alaska; Northwest Community College in Nome, Alaska; and three offerings at Fairbanks, through the University of Alaska Statewide System. As part of the grade requirements for the course, students were required to write a synopsis paper, after completion of the coursework, which reflected how the codependency material affected their own understanding of the relationship between and their families of origin or families of ordination and when it was applicable in their own recovery. The codependency course was also approved for state certification as a substance abuse counselor. The primary materials for the course consisted of transcribed audio-tapes from the National Conference on Adult Children of Alcoholics held in San Francisco, California in February of 1990. Students also read two texts: Diagnosing & Treating Co-Dependence by Tim Cermak, published by Johnson Institute Books, 1986; and, The Self-Sabotage Syndrome/Adult Children In the Workplace by Janet Woititz, published by Health Communication Inc., 1989. In summary, their were no specific Native American authors on codependency included within the training manual. There were also six videotapes utilized for the course, one of which did contain an interview of a Native American Recovering Codependent. This was a tape titled: Taking Care of Ourselves by Melody Beattie. We also utilized two videos from the John Bradshaw Series: Bradshaw On The Family; Numb by Janet Woititz; Codependence from the Phil Donahue Show; and, the video, Codependence: Joy Of Recovery, by Tim Cermak.

DEVELOPMENT

After completing the course evaluations, and reading the student synopsis reaction papers, a new emerging problem or concept appeared. Many of the Alaskan Native students began to question the role of how their cultural values may have formally worked quite well, but, now that reinterpretation might indicate a new cultural problem. What is this new problem? Is there a concept wherein one could say that some codependence is both good and bad or functional and or dysfunctional? What role does cultural enabling have in the development of dysfunctional codependence? Can the present Inupiat value system become culturally conflictual, such as inappropriate sharing or inappropriate caretaking instead of appropriate care-giving? Can there be a delayed environmental reaction to a formerly accepted cultural practice that is now considered or reinterpreted as "enabling" or inappropriate? One former Inupiat Student put it this way during the course: "Now if you think I'm going to tell my relatives and elders that what they have been doing for the last forty years that I have known them is not any longer appropriate, you have another guess coming, I just can't do that to my people!

What we are suggesting is: now that this new phenomenon has emerged in the field of chemical dependence called codependency, how does this relate to the Alaska Native Culture and their value system and can this phenomenon create even more problems for people in treatment, or should we look at this as a critical variable which may precipitate relapse, especially for those Natives in recovery who return to a dysfunctional familial environment?

Before we go any further, it would seem appropriate to define both codependence and its probable relationship to post-traumatic stress disorder and then on to post-traumatic cultural disorder. We also have several case study synopsis reaction papers included in our presentation. We

also have several case study synopsis reaction papers included in our presentation. We will be performing an exercise in which we will give you the opportunity to review the cases and attempt to identify two issues: one, what are the codependent cultural value conflicts which may be culturally problematic?

First, a story. The Director of the Training Office has the opportunity to meet an elder Athabascan, who took a course titled: Alcohol, Suicide, Death and Grief (a really uplifting training event). During the training, this elder stated that he was a very successful member of his predominately Native community and was also a very successful fish buyer and seller. He had a large family and consistently assisted other members of his family who were only seasonally employed; several were, in his words: "practicing alcoholics". He said that he bought them snowmobiles, fuel oil, groceries and gave them money for utilities during the cold Alaska winter. After a fiery debate about "cultural enabling" and the role of interventioning of suicidal and or chemically dependent clients, he said that he was going to perform and assist in several "interventions" in his family and also pay bills directly, without giving his relatives access to money which was used for drugs. The pain and anguish on his face within the next month, for the second half of the course, was very evident and, in fact he broke down and cried in the classroom because he said he was obligated to help those who were less fortunate than himself, as: "We Athabascan people have always done for those in need, especially during death, grieving and the local potlatch". This Athabascan elder also stated that, according to his culture, it was not appropriate for him to "interfere" with what his family members did and initially translated the word "intervention" as "interfering". Is there some cultural traumatizing disordering within this story?

Second story: An Inupiat Eskimo Certified CD Counselor revealed after a training event on codependence that she was living with, and married to a "practicing alcoholic husband who 'plays with subsistence' and hates me working and being the man supporter of the large family who has had two unsuccessful interventions performed on him". The second oldest daughter, living at home, is her sole confidante and always helps around the house and with expenses. As I listened to the family situation, it was seemingly apparent that the daughter was performing as the surrogate husband, providing financial and emotional support for the family. When this daughter left to attend a vocational college, the family became so dysfunctional that she was "forced" to return for economic reasons and also for emotional support, after another crisis from her husband's alcoholism. Is there some cultural codependence in this story which could become traumatizing for this family in relationship to enmeshment and/or abandonment and shame? Could some appropriate values, inherent in the Athabascan and or Inupiat Eskimo family structure, become culturally conflictual?

At the 1990 AFN Convention (Alaska Federation of Natives) a paper was distributed to the convention delegates. The author is a Yupiq Eskimo form Hooper Bay, Alaska. The title of the paper was: "YU'YA'RAY: THE WAY OF THE HUMAN BEING" by Harold Napoleon. He wrote the paper at the Fairbanks Correctional Center where he is serving a term for the murder of his son, which he committed while under the influence of alcohol. The paper addresses the problem of alcoholism among Alaska Native people and his major thesis relates to the Great Death of Alaskan Natives, due to epidemics and the resultant Post Traumatic Stress Disorder associated with this great loss for Native People. At this time I would like to quote several passages from this creative and insightful paper.

The New Yupiq was born into a cultural rubble, physically and psychologically traumatized. He was born into a world no longer anchored. He was born adrift and lost. In this condition he walked out into the 'new world'. It was this traumatized, demoralized, confused, afraid and lost Yupiq who embraced Christianity overnight, who abandoned Yu'ya'ray, discarded his spirit world and his ceremonies, and buried his old culture in the silence of denial....Post Traumatic Stress Syndrome, in time, cripples a person. The act of suppressing the traumatic event, instead of expunging it from the mind through 'confession', serves instead to drive it further into the psyche, or soul of the person, where it festers and begins to color the life of the person... Because of his guilt, the person suffering from PTSS does not like himself. He is ashamed of himself, ashamed of what he saw or participated in, and is haunted by the memory. He becomes withdrawn, hypervigilant, hyper-sensitive, and is constantly living in stress. Soon, he is unable to speak truthfully with other people about himself or his feelings and

becomes unable to carry on close interpersonal relationships. Living under a great deal of stress in his soul, he becomes less and less able to deal with even the minor difficulties of everyday life.[1]

Judging from the abrupt changes the Yupiq and other Native people accepted at the turn of the century, literally without a fight, one can assume that they were not 'themselves'. No people anywhere will voluntarily discard their culture, beliefs, customs, and traditions unless they are under a great deal of stress, physically, psychologically, or spiritually... But we hear them today. They cry in the hearts of their children, their grandchildren, and great-grandchildren. They cry in the hearts of those children who have inherited the symptoms of their disease of silent despairing, loneliness, heartbreak, confusion and guilt. And tragically, the children, not knowing why they feel this way, blame themselves for this legacy from their grandparents, the survivors of the Great Death who suffered from what we now call PTSS.... The survivors were stoic and seemed able to live under the most miserable and unbearable of conditions. They were quiet, even deferential. They did not discuss personal problems with others. If they were hurt, they kept it to themselves. If they were angry, they kept it to themselves. They were lauded as being so respectful that they avoided eye-to-eye contact with others. They were passive - very few exhibited their emotions or discussed them.[2]

It is the opinion of Mr. Napoleon that many of today's difficulties for the Alaskan Native can be traced back to the great epidemics which swept over many parts of this state in 1900, resulting in the great influenza outbreak that purported to have killed 60% of the Eskimo and Athabascan people and the outbreak of tuberculosis.

Another major culturally-traumatizing event in some Alaskan native peoples' life was the dislocation and relocation to Native Boarding Schools located in Sitka, Wrangel, and also in Oregon. The parents of those Alaska Natives removed from their homes were denied the opportunity of parenting and, also, the dislocated children did not see effective parental modeling behavior. What role could this have in the present-day family of dysfunction? Now, add the additional overlay of chemical dependence and/or physical, sexual, or emotional abuse and one can see how the family of origin became a "compromised environment", which could be passed from one generation to another.

Before we proceed into the development of our concept (Post Traumatic Culture Disorder/Functional & Dysfunctional Codependence (Enmeshed Codependence)), let's review several definition of just what codependence is. Terry Kellogg defines codependence as: "...the absence of relationship with self, a child's reaction to a dysfunctional family. When children live with people who are not dependable, the child never learns to depend on others or self in healthy ways; they depend on fixes, external and inappropriate people. They allow people to depend on them, or they isolate and appear independent. Dependency on externals becomes addiction. Codependency is a symptom of abuse and the loss of identity, which is self-intimacy. Codependency is usually defined through its symptoms and is often treated by non-recovering codependents."[3] Tim Cermak defines codependency as: "...a recognizable pattern of personality traits, predictably found within most members of chemically dependent families, which are capable of creating sufficient dysfunction to warrant the diagnosis of mixed personality disorders."[4] Robert Subby defines codependence as: "...a pattern of living, coping and problem-solving created and maintained by a set of dysfunctional rules within the family or social system. These rules interfere with healthy growth and make constructive change very difficult, if not impossible.[5] Minirth and Meier define codependence as: "...an addiction to people, behaviors, or things. Codependency is the fallacy of trying to control interior feelings by controlling people, things, and events on the outside. To the codependent, control or the lack of it is central to every aspect of life. The codependent may be addicted to another person. In this interpersonal codependency, the codependent has become so elaborately enmeshed in the other person that the sense of self- personal identity - is severely restricted, crowded out by that other person's identity and problems. Additionally, codependents can be like vacuum cleaners gone wild, drawing to themselves not just another person, but also chemicals, (alcohol or drugs, primarily) or things - money, food, sexuality, work. They struggle relentlessly to fill the great emotional vacuum within themselves.[6]

Let's keep in mind that "codependent" literally means "dependent with". Several key concepts of the various definitions center around the codependent's concentration on "other(s)" or what Bradshaw labeled as "otheration". In other words, the codependent, as a result of living and adjusting

to a dysfunctional person or environment, becomes so overwhelmed and controlled by this situation that they lose "sight of themselves", sometimes completely and totally. This control issue is one of the major problems of codependents.

CHARACTERISTICS OF CODEPENDENCY

Tim Cermak lists five main major characteristics of codependents:

1. Codependents change who they are and what they are feeling, to please others.
2. Codependents feel responsible for meeting others peoples' needs, even at the expense of their own needs.
3. Codependents have low self-esteem.
4. Codependents are driven by compulsions.
5. Codependents have the same use of denial and distorted relationships to will power that typifies active alcoholics and other drug addict.[7]

Minirth, Meier and Hemfelt list ten major characteristics of codependence:

1. The codependent is driven by one or more compulsions.
2. The codependent is bound and often tormented by the way things were in the dysfunctional family of origin.
3. The codependent's self-esteem (and frequently maturity) is very low.
4. A codependent is certain his or her happiness hinges on others.
5. Conversely, a codependent feels inordinately responsible for others.
6. The codependent's relationship with a spouse or Significant Other Person (SOP) is marred by a damaging, unstable lack of balance between dependence and independence.
7. The codependent is a master of denial and repression.
8. The codependent worries about things he or she can't change and may well try to change them.
9. A codependent's life is punctuated by extremes.
10. A codependent is constantly looking for the something that is missing or lacking in life.[8]

Some of the common themes expressed by both Cermak and Minirth, Meier, and Hemfelt are the roles of relational difficulties for codependents and the resultant low self-esteem associated with a client's problems with intimacy in his/her life. Within our own state of Alaska, another key stage codependent characteristic extends to other addictions or poly-addictions within dysfunctional families.

Another common theme in our state concerns the issues of accidental death, which quite often is alcohol-related, and suicide. When these issues are within one's family of origin, issues that are not adequately grieved and/or resolved, the potential set-up for codependence may be quite strong.

The issue of denial also needs exemplification. It is our position that denial cannot only impenetrable for the chemical dependent person, but also maybe even stronger for the codependent person, who seldom sees his/her source as the problem itself. We can also see evidence of community-side denial as it relates to chemical dependence and codependence.

The following is an attempt to look at cultural traits, individual traits, society traits and other codependent descriptions to assist you in looking at our case studies. This is an attempt at characterization through a memory peg titled: NATIVE AMERICAN ALASKAN CULTURAL DYSFUNCTIONAL FAMILIES.

TABLE 1

N EVER IN ANGER EXPRESS FEELINGS
A RRESTED DEVELOPMENTAL NEEDS
T RIANGULATED COMMUNICATION PATTERNS
I NDIRECT COMMUNICATION PATTERNS
V IOLENCE PRONENESS UNDER THE INFLUENCE & VIEW OF LIFE AS PROBLEM TO BE SOLVED
E NMESHED BOUNDARIES ENTANGLED BOUNDARIES & ENGULFED BOUNDARIES BLENDED BOUNDARIES

A DDICTIVE DESTRUCTIVE RELATIONSHIPS
M ARTYRDOM
E NABLING RELATIONSHIPS IN EXTENDED FAMILY ESPECIALLY
R ELATIONAL DIFFICULTIES
I NTIMACY PROBLEMS
C ONSTRICTED FEELINGS
A BSENCE OF SELF INTIMACY
N UMBNESS

A CCIDENTAL DEATH PRONENESS
L ACK OF BOUNDARIES AND LACK OF BALANCE OF MEDICINE WHEEL
A LCOHOL RELATED DEATHS
S UICIDE, SHAME AND SURVIVORS GUILT
K INRED PROBLEMS
A VOIDANCE SYNDROME
N OT TRUSTING

C ULTURAL DISORDERS
U NSTABLE VALUES IN COMMUNITY, FAMILY, PERSON
L OSS OF ROLE OF ELDERS
T RADITIONALNESS LOSS
U NDIFFERENTIATED VALUES
R E-EXPERIENCING AND DISLOCATION
A BANDONMENT AND DISLOCATION
L OSS OF INDIANNESS/IDENTITY

D ISSOCIATION AND DISLOCATION
Y ESMAN/PERSON PEOPLE PLEASING ORIENTATION
S TRESS-RELATED ILLNESS
F IXATIONS
U NPREDICTABILITY
N O COMMUNICATION RULE WITHIN THE FAMILY
C ONTROL MADNESS/PROBLEMS
T RUST ISSUE PROBLEMS
I DENTITY PROBLEMS
O THERATION
N O TALK RULES
A VOIDANCE OF PROBLEMS SYNDROME
L ACK OF NURTURING

C ATASTROPHIC FAMILY OF ORIGIN OR ORDINATION
O THER DIRECTED OUTER DIRECTED OR OBJECTIFICATED
D ISTORTED IDENTITY
E LDERLESSNESS IN CULTURE ROLE
P ARENTAL MODEL FAULTY MODELING MOLLY HOOTCH PHENOMENON OF DISLOCATION
E NVIRONMENTAL OPPRESSION WITHIN FAMILY
N EGLIGENCE OF DEVELOPMENTAL DEPENDENCY NEEDS
D ENIAL AND DELUSION AND MAGICAL THINKING THAT FAMILY WAS OK
E XTERNAL ORIENTED
N O COMMUNICATION WITHIN FAMILY
T RANCE OF FAMILY PASSED ON TO NEXT GENERATION ADDICTIVE CYCLE NOT BROKEN

F ALSE IDENTITY
A BUSE ISSUES, SEXUAL, PHYSICAL, EMOTIONAL
M ANIPULATIVE LIFE STYLE
I MBALANCE IN LIVING
L IVING WITH STRESS
I NTIMIDATED WILL
E MOTIONAL PROBLEMS
S EXUAL, SPIRITUAL AND SUBSISTENCE-ORIENTED BANKRUPTCY

(CODEPENDENCY TRAITS/DESCRIPTIONS)

TABLE 2
TWO-WAY NATIVE AMERICAN VALUE ORIENTATION

TRIBAL TRADITIONAL VALUES	VERSUS	URBAN INDUSTRIAL VALUES
GROUP EMPHASIS	NATIVE AMERICAN INTROJECTS	INDIVIDUAL EMPHASIS
PRESENT ORIENTATION		FUTURE ORIENTATION
TIME ALWAYS WITH US		TIME USE EVERY MINUTE
AGE		YOUTH
COOPERATION		COMPETITION
HARMONY WITH NATURE	NATIVE AMERICAN PROJECTS	CONQUEST OVER NATURE
GIVING & SHARING		TAKING & SAVING
PRAGMATIC	CONFUSED VALUES	THEORETICAL
MYSTICAL		SKEPTICAL
PATIENCE	RESULTS OF TRYING TO LIVE IN	AGGRESSION
LISTENING SKILLS		VERBAL SKILLS
RELIGION WAY OF LIFE	OR UP TO BOTH VALUE SYSTEMS	RELIGION SEGMENT OF LIFE
MODESTY	(ANXIETY/FRUSTRATIONS/STRESS)	SELF-ATTENTION

COMPARISON OF CULTURAL VALUE SYSTEMS & INUPIAQ ILLITQUSIAT PROGRAM ESKIMO VALUES
(ESKIMO SPIRIT MOVEMENT)

Tribal Traditional Cultural Values	Inupiaq Values	Middle Class, Urban Values
Group, Clan or Tribal Emphasis	Responsibility to Tribe	Individual Emphasis
Present Oriented		Future-Oriented
Time, Always with Us		Time, Use Every Minute
Age	Respect for Elders	Youth
Cooperation	Cooperation	Competition
Harmony with Nature	Respect for Nature	Conquest for Nature
Giving, Sharing	Sharing	Saving
Pragmatic		Theoretical
Mythology		Scientific
Patience		Impatience
Mystical		Skeptical
Shame		Guilt
Permissiveness		Social Coercion
Extended Family & Clan		Immediate Family
Non-Agressive		Aggressive
Modest	Avoid Conflict	Over-Confident
Silence	Family Roles	Noise
Respect Others' Religion	Avoid Conflict	Convert Others To Religion
Religion a Way of Life	Humility	Religion, A Segment Of Life
Land,Water,Forest Belong to All		Land, etc. a Private Domain
Beneficial, Reasonable use of Resources	Spirituality	Avarice, Greedy Use of Resources
Equality	Spirituality	Wealth
Face-to-Face Government	Respect for Nature	Representative Democracy
Low Self-Value	Respect for Nature	Strong Self-Importance
Compact Living,Close Contact	Sharing	Space Living, Privacy
Life Adult-Centered		Life-Child-Centered
Children Participate in Adult Acts.	Respect for Others	Adults in Children's Acts.
Life is Hard and Dangerous		Life is Easy, Safe, Bland
Children Can Only Hope for Much Clothing & Toys	Love for Children	Many Toys and Much Clothing Is an Acceptable Value.
	Hard Work	
	Love for Children	
	Love for Children	
	Domestic Skills	
	Knowledge of Inupiaq Language	
	Knowledge of Family Tree	
	Humor	

CULTURAL VALUE CONFLICTS
TABLE 3

Functional Codependence	Dysfunctional Codependence
1. Institutionalized sharing of parenting duties during crisis, illness, travel, death or another emergency by extended family in village or community.	1. Cultural enabling behaviors that allow child abuse, neglect, sexual or emotional abuse and chemical dependence to progress to critical stages due to surrogation of familial duties by clan or extended family.
2. Institutionalized sharing of monetary resources to assist needy families with utility costs, etc. Also sharing of subsistence acquired food.	2. Sharing of drugs and or alcohol automatically with friends, relatives without necessary funds, cultural enabling to progression into dependency.
3. Group, clan, tribal village community emphasis oriented toward cooperation and extended family based on historical survival patterns of behavior with responsibility to tribe.	3. Enmeshed and blurred boundaries of roles leading to surrogation of dysfunctional familial roles leading to codependence that may become dysfunctional.
4. Avoidance of conflict within family and village and community oriented toward harmony, and cooperation, and respect for others.	4. Oppressive no talk rules within family may lead to maladaptive patterns of roles may be released in violence upon intoxication or disruption of grieving cycle during accidental death or suicide leading to delayed multiple grief and or depression. Problematic interventioning.
5. Appropriate care-giving and sharing.	5. Inappropriate care-taking.
6. Intra-tribal or ethnic marriage patterns.	6. Inter-tribal marriage or inter-racial marriage leading to loss of cultural identity, and especially loss of language and custom may lead to addiction to dysfunctional marriage, misery or other problems culminating into potential clan, family, tribal or village abandonment.
7. Governmental autonomy of social services within non-profit corporations to localize delivery and ownership responsibilities for those services.	7. Possible dependency on these services without monetary cost or responsibilities which can lead to post-dependency, for example, multiple admissions for treatment of chemical dependency within IHS funded programs.
8. Missionary conversion to religion and acceptance of christian way of life.	8. Spiritual bankruptcy and confusion and guilt and/or shame due to being denied access to cultural ceremonial religious practices.

9. Culturally assigned family roles for men, women, children and elders.	9. With many women as sole providers for the family, many men have lost their role as provider, loss of identity and potential codependent relationship to wife leading to blending, blurring and enmeshed roles leading to loss of identity.
10. Respect for role of elders and good dependence on their knowledge and teaching and blessing of long life for those who lived by Inupiaq Values.	10. Some elders are chemically dependent and/or perpetuators of abuse which can lead to non-intervention due to respect for role of elders and non-confrontation.

POST TRAUMATIC STRESS SYNDROME/DISORDER

Now that we have covered the definition of codependency, looked at both cultural or communal and individual codependent characteristics, let us turn our attention to the phenomenon of PTSS/PTSC, before we develop our lost concept of PTCD (Post Traumatic Culture Disorder). Just exactly what is PTSS/PTSD. Many of our returning Vietnam Veterans experienced a delayed reaction to the trauma, death, and unresolved grief (for many) which they lived through in Vietnam. In fact, some of the war images seen in the present-day Gulf War (Operation Desert Storm) may re-ignite some unresolved issues for those veterans. In addition, some soldiers maybe traumatized by witnessing sudden death resulting from the SCUD attack on one of our army barracks, which injured and killed many U.S. Servicemen and women. Some professionals in the field have called those delayed reactions adjustment disorders. While in Vietnam, many of our soldiers had to adapt into what are called "survival roles". One's identity may have been lost during this adaptation phase and most importantly, what those soldiers did with their feelings when they saw a "buddy" dismembered by a mine explosion just several feet away from them. This loss of emotion is sometimes called "emotional constriction" and is a way of protecting oneself in "harms way". Some of the delayed symptoms of PTSD are: survival, guilt and shame, psychic numbing, re-experimental trauma, hypervigilance, memory loss, sexual and sleep disorders, etc. How does this relate to codependence and familial dysfunctionality?

In a typical alcoholic and/or chemically dependent home, member of the family take up survival roles as a result of adjusting to a situation which has been called "crazy making". Let's assume that a fourteen-year-old teenage daughter comes home from school and finds her mother passed out in the nude on the couch and appears not to be breathing. Or, she comes home and finds her mother with another man, caught in the act of love-making, also in the nude. This can certainly be a traumatizing event and may be even more traumatizing if the child or children is seven and the scene repeats itself. Another scenario could be an alcoholic father sexually abusing his daughter while under the influence of alcohol or the daughter becoming his "surrogate wife" and then sexually exploiting this situation. Many "survivors" in that "role" may very well block out all cognitive and, most important, physical and psychological meaning to those events in order to protect theirselves from the potential psychic scarring of the event.

Let us now return to the words of Harold Napoleon as he pondered the role of PTSS/PTSD:

To such a person, escape from self becomes a necessity because even in sleep he finds no peace. He becomes a 'runner', running form his memory, and from himself. He gets tired, begins to despair, and for him, in this day and age, alcohol and drugs become a readily available 'escape' from the illness. These, for a time, are able to numb his mind and his soul. In time, without treatment, many veterans and others who suffer from PTSS become alcohol and drug abusers. Many become addicted, and, as

a result, lose friends, wives, families and become isolated, exacerbating an already bad situation. Being unable to hold jobs, some become dependent upon others for support. Tragically, under the influence of alcohol and drugs, the pent-up anger, guilt, shame, sorrow, frustration and hopelessness is vented by outbursts of violence to self and others. Such acts, which are difficult for others and even for the sufferer to understand, drive him further into the deadly vortex of guilt and shame. Family and friends who knew him before he became ill, swear that he is not the same person, and that they do not know him anymore. Post-traumatic stress disorder is not a physical illness, but an infection of the soul - of the spirit.[9]

Napoleon continues:

Not all the survivors of the Great Death suffered from post-traumatic stress syndrome, but a great many did. This may explain the great thirst for liquor that whalers and other Westerners found in the Eskimos along the Bering Sea and the Arctic. ...Like the Vietnam veteran, or victims and witnesses of other violent and traumatic events, these Eskimos found in liquor a narcotic which numbed their troubled minds. The reports of the whalers, the revenue cutters and other observers confirm that Eskimos quickly became addicted to alcohol. The only explanation for this type of behavior is that for some reason these Eskimos were psychologically predisposed to seek 'relief' through the narcotic effects of alcohol.... The numbers are shocking - the number of suicides, the number of homicides, the number of accidental deaths, the number of dismemberments, the number of domestic violence incidents, the number of imprisonments, the number of fetal alcohol children, the number of deaths by disease attributed to alcohol abuse, etc. Yet these numbers are misleading because they do not measure the damage being done to the Native people. The number cannot quantify heartbreak, discouragement, confusion, hopelessness, grief. The numbers cannot measure the trauma. It is like repeating the Great Death all over again, and just like then, the Alaskan Natives blame themselves and do not know or understand why. And like the first Great Death, a whole generation of Alaskan Natives are being born into trauma, just like their grandfathers and fathers. It is history repeating itself in a very tragic and heartbreaking way. It is a deadly cycle which began in the changing of the times for the Yupiq and the other tribes of Alaskan Natives.[10]

POST TRAUMATIC CULTURE DISORDER

Our definition of PTCD is "the re-experiencing of a traumatizing cultural and/or familial Native American value loss". What are the origins of this cultural codependence? It is our position that the dysfunctional family is the origin of most of the cultural codependence; however, government policies may also foster the codependence within the culture. Some of the childhood issues that can create PTCD and dysfunctional codependence are the following:

1. Extended family enabling.
2. Child abuse, neglect, including physical, sexual, emotional.
3. Governmental dislocation and/or relocation, especially boarding school.
4. Abandonment.
5. Gender/role problems.
6. Lack of access to cultural and/or survival subsistence due to government policy.
7. Constricted familial emotional patterns.
8. Surrogation of traditional familial roles.
9. Enmeshed families.
10. Conflictual value systems between Western Culture and Native Culture.
11. Faulty parental modeling of inappropriate or non-existence parenting skills.
12. Loss of spirituality.
13. Loss of communication inter- and intra-familial.
14. Loss of appropriate grieving patterns.
15. Adjustment reactive disorders to intergenerational chemical dependence.
16. Governmental dependency.

NATIVE AMERICAN VALUE CONFLICTS/FUNCTIONAL & DYSFUNCTIONAL CODEPENDENCY

The reader is referred to Table 2 Labeled "Two Way Native American Value Orientation". This table references the difference's between traditional tribal values versus urban industrial values and then looks at a comparison between tribal traditional cultural values, the Inupiaq value, spirit movement values, and lastly, middle class, urban values.

It is important to state that many Native families incorporate many different composites of all those values. Our major concern here is being "caught" in various value conflicts, with or without one's awareness. In addition, children growing up in dysfunctional families, also have to adapt to various survival roles and values from both Native and non-Native "worlds".

When Native Americans introject various values, what does it mean? Introjection is defined as: "the incorporation unconsciously into the psyche (a mental image of an object, person, etc.) and focus aggressive energy upon this image rather than the object itself". Thereafter, the Native American may project those values which are now confused and the result may be stress, anxiety, frustration, and possible unconscious dysfunctional codependency. Projection from a psychiatric point of view means the "unconscious act or process of ascribing to other one's own ideas, impulses, or emotions, especially when they are considered undesirable or cause anxiety".

The reader is now referred to Table 3, titled: "Cultural Value Conflicts/Functional and Dysfunctional Codependence". A review of this table will allow the reader to understand how the value conflicts can specifically lead to both functional and dysfunctional codependence. Let's take a look at several examples:

An Inupiaq counselor trainee, working in Kotzebue, Alaska, is asked by a client who is a "relative", for some specific money to pay utility back payments for fuel oil and the telephone. She gives her "client-relative" the money based on her own cultural perspective of sharing with those in need. She enters this in her "progress note" in the client file and, at a staff meeting is formally sanctioned for violating provisions of the State Of Alaska Substance Abuse Counselor Code of Ethics pertain to maintaining a professional relationship with a client. The "dressing down" of the client brings forth memories of her Caucasian Step-father who also "dressed her down" for constantly loaning out her allowance to other Inupiaq students who didn't have money for a "hot" lunch. She becomes overloaded with feelings from that incident. Her clinical supervisor has been on the job for less than three months, is from the "outside", is non-Native, and failed to understand some of the cultural dynamics of the norm associated with "sharing" in the Inupiaq culture.

An Athabascan Human Services Certified Alcohol counselor is taking a course in Native culture and cross-cultural counseling at the University of Alaska, Fairbanks and the professor instructs the students to form into groups for a task which identifies the advantages of Native-only counseling Native clients. He/she assigns a transcriber and a facilitator due to time limitations, and gives instructions for the exercise a second time. The Native Athabascan is "assigned" the role of facilitator to recognize her recent "certification" and places a time limit of twenty minutes for the exercise, outlining the final task product. The student is translating from English to Gwitchin and the transference of the "authoritarian" oriented professor flashes her back to her BIA boarding school experience in which she was hit with a straight edge ruler for speaking her Native language in class. She becomes immediately distraught. Out of respect, does not want to assert herself by stating that she is not up to being the "facilitator" and is uncomfortable with being praised for her "certification". She is so upset that she asks for directions a third time for the exercise and becomes passive-aggressive.

She begins to reexperience the trauma of her BIA experience; is caught up in showing respect to the professor and not wanting to "facilitate"; begins to remember the shame and humiliation of the previous experience of being hit and "dressed down" for speaking Gwitchin' decides to "walk out" of the class; and, becomes even more distraught by letting her "group" down.

At this point we are going to take a look at a composite case study which will serve as the means for tying together several of our concepts of both PTCD and functional and dysfunctional codependence. As you read the case study, keep in mind the survival roles within this "dysfunctional family". The case study is from Susan Soule's book: Finding Our Way: Ideas Issues in Suicide Prevention (Bethel, Alaska: YKHC, 1988)pp 8-10.

A YOUNG PERSON IN TWO CULTURES: PEOPLE'S CULTURE & OTHER CULTURE

Let's call our young Yupik man Tom and let's suppose that his dad was a fine hunter provided enough food for his family with some left to share with others. Suppose that Tom's dad's abilities as a provider gave him status in his community, that others looked upon him as a leader. Imagine what

happens when conditions change so that hunting becomes more difficult. This happened to many Native groups in North America when they were forced to live on reservations, close together, unable to travel widely in pursuit of game. It happened on the delta(Yukon Kuskokiwm) when people became less free to travel in pursuit of game and when fish and games laws limited seasons and harvest amounts. Along with restricted subsistence activities came stores selling "White man's food and White man's things". How was Tom's father to buy these things for his family? How was he to earn the money?

Tom's father could no longer provide all the things his family wanted. He no longer structured his days through the needs of hunting. From being very busy, he went to having little to do. He felt badly that he no longer could provide everything for his family. He began to feel increasingly useless to question his own worthiness as husband and provider. As this happened, Tom's father began to withdraw, to turn in upon himself. He grew short-tempered and yelled at Tom when before he would have been patient. He spent less and less time teaching things to Tom and the other young boys because the things he knew no longer seemed important. He also withdrew from his wife.

Tom's home was no longer a happy place where everyone shared the work and felt needed and loved. If Tom's parents abused alcohol, home was an even more difficult place, unpredictable, at time even dangerous. Tom's childhood wasn't happy any more. Tom felt less loved and less secure in his home and family. When Tom started school he discovered a lot of things about himself that he was expected to change. He had to learn to speak a different language and to learn the concepts and images of the culture that language belonged to. Not only were the words in the books he was given strange, but even many of the pictures had little meaning to him. He had to behave differently than he did at home. He had to learn a lot of new things and if he didn't learn fast enough or do these new things the way the teacher wanted him to, he felt embarrassed and ashamed. He wasn't at all sure he could succeed in this new world of school. He began to thing that maybe he wasn't too smart.

Gradually Tom became more comfortable in the new language than in his old language. There were ideas and feelings he could only express in the new language, a language his parents spoke only a little. It became harder and harder for Tom to talk to his parents, or his parents to him, about the things they were thinking and feeling. The school also introduced Tom to a lot of things that he liked, things that were new to him, new to his people. He enjoyed basketball and the trips to the city that his classmates went on. He liked movies and television and rock music.

After school, he liked to roar around on a snowmachine and wanted to earn the money to buy one of his own. He started thinking about what he would do after high school. Tom realized his teachers placed the highest value on going to college, but also that they didn't seem to believe Tom could succeed in college, that he might do better in vocational training. Tom felt his teachers didn't really think much of his abilities. Tom didn't feel too much confidence in himself.

Not all of Tom's friends are as troubled as Tom, but many are. Not all the Toms get drunk one day and find the feelings of helplessness becoming feelings of anger, anger at themselves, at others, at life, but too many do. And too many turn the helplessness and anger on themselves and end their own lives. Too many turn the anger on their families and friends and commit acts of violence on others. Too many just don't value themselves and their lives enough to be careful and die in accidents.

OPTIONAL CLASS EXERCISE

INSTRUCTIONS: Review the case study on Tom, the Yupiq Eskimo client, and identify the following:

1. Native cultural values.
2. Non-Native cultural values.
3. ACOA dysfunctional characteristics.
4. Codependent functional characteristics.
5. Codependent dysfunctional characteristics.
6. Post-traumatic cultural disorders.
7. Sources of confusion, consequences, and problems for the composite individual as they relate to values, role expectations, parent and elder roles, elements of traditional values conflict with current living conditions, and introduction of alcohol.

(A) Source of confusion
(B) Consequences
(C) Individual/Village Problems

PTCD & FUNCTIONAL/DYSFUNCTIONAL CODEPENDENCY REVISITED

In looking over our case study of Tom, the major potential codependent problem concerns the loss of self-identity, one of the major definitions of codependency, the loss or absence of relationship with "self". We also see a major failure to develop a strong sense of identity and a failure to feel that he belonged. Another major concern is the communication patterns between elders, youth and adults and one of the major resultant products may be the statement: "I no longer know what it means to be Indian!". This loss of identity sets up a stage for severe and potential traumatizing difficulties in the present and future relational life of our clients. It is the difficulty with relationships that becomes one of the more pronounced characteristics of codependent person along with control issues and issues surrounding boundary development. An excellent summary of these issues, again comes from the pen of Harold Napoleon as follows:

Today's generation of Alaska Native people are a generation which have turned on themselves. They blame themselves for being "unemployed", for being second class citizens, for not being "successful" as success is portrayed to them by the world we live in. They measure themselves by the standards of the television America and the textbook America, and they have "failed". For this they blame themselves. There is no one to tell them that they are not to blame, that there is nothing "wrong" with them, that they are love. Sometimes they don't even know who they are, or what they are.

This, of course, does not describe all young Alaska Natives people. But it describes the suicides, the alcohol abusers, the ones in prisons, the ones with "nothing to do" in the villages. These are the numbers we hear in reports. They are living human beings - Eskimos, Aleuts and Indians - the ones we pay no attention to until they become a number. Chances are good that their parents themselves were alcohol abusers, if not alcoholics. Chances are good they saw violence in the home - physical, verbal, psychological. Chances are good that they were "ignored" not paid attention to. Chances are good that they were disappointed as children, emotionally hurt, heartbroken. Chances are good they thought themselves unloved, unwanted. Chances are they knew hunger, were dirty, rested little, and didn't not do well in school. Chances are that they were disappointed by their parents - maybe they loved them, but were not loved in return. Chances are they yearned for happiness and a normal home but were denied it. Chances are they no longer communicate with others - not their parents, not their relatives, not their friends, with no one.[11]

By the time they are grown they are deeply depressed in their souls. By the time they are grown they have become demoralized, discouraged, and do not think very much of themselves. Deep in their hearts, they are hurt, angry, frustrated, and confused children. They never talk, they have turned inward.....So what caused this? Is it the young man's or young woman's fault? Or is it his or her parents fault, themselves abusers and alcoholics? Or is it the grandparents' fault who somehow did not raise their children right because they themselves were traumatized by the Great Death and later felt guilt for this and the subsequent loss of culture, and language and independence? Whose fault is it?.....My answer at least is this. That we, who are indeed the survivors of the Great Death must end it. That we must put all our energies and resources to end it..... We must speak.....because we don't know each other anymore, we have become strangers to each other. The old do not know or understand the young, and the young do not know or understand the old. Parents do not know their children, and the children do not know their parents. As a result of this silence, a gulf has grown between those who love and care for each other the most. It is so very sad. I have been in homes where members of the same household do not even speak to each other. I wondered how they could even stand to be in the same house together like this. And out of this will come more hurt, misunderstanding, and unfulfilled love. Even in the family, while surrounded by those one loves the most, a person can become very lonely, isolated, alone - a stranger even to those who love him, to those closest to him. An needless to say there will be tension, stress and very frayed nerves. Only communication, honest communication, from the heart, and truthful, will break this down, because inability to share one's heart and feelings is the most deadly legacy of the Great Death. It was born out of the survivors' inability to face and speak about what they had seen and lived through. The memory was too painful, the reality too hard, the results too hard to hear. Without knowing it, the survivors began to deal with life and the difficulties of life this way, by trying to ignore them, by denying them, by not talking about

them. And this is the way they raised their children, and their children raised us the same way. It has become a trait among our families, our people, holding things in. The results have been tragic....Since the late 1960's, we have seen the breakdown. Alcohol abuse has become rampant. Violence in the home and village directed at others and at self-destruction of the Alaska Native is shocking. It is appalling. The only way it will end is if the built-up stresses, misunderstandings, and questions are released and satisfied by truthful dialogue from the heart. It is only through this heart-to-heart dialogue, no matter how painful or embarrassing the subject, that the deadly stresses born of trauma on trauma, can be released. Then, slowly, we can all go home again, be alone and lonesome no more, be a family and a village again....Free to become what we were intended to be by he who created us.[12]

It is our opinion that Mr. Napoleon has accomplished a very clear picture of the typical "dysfunctional" home and the resultant, almost total lack of communication that is passed on from one generation to the next with a no talk rule. Survival roles must be adapted to live in environments hat Mr. Napoleon delineates so somberly. When one attempts to "control" and live within this environment, it is quite clear how the impact on the development of the self occurs. The major impact here concerns the issue of faulty parental modeling of behaviors and the most immediate concern is how does the affected child or children get impacted in his or her normal developmental needs and tasks, which should have been performed during this period of development. It is no wonder how and why this type of person runs into severe difficulties in his or her emotional and relational life. This stunted emotional growth can have catastrophic consequences at a later date and may lead to suicide for some clients. If there has been little opportunity for dating due to everyone being related to each other in a village, the client falls "in love" and the partner falls "out of love". The person is twenty-three chronologically, but emotionally thirteen. He/she has no previous developmental skills to handle this transitional phase and coupled with the potential of alcohol-affected, pent-up emotions, one can easily see how a suicide attempt or completion may be an acceptable alternative.

ENMESHED CODEPENDENCE

What is enmeshed codependence? When the boundaries and roles within a dysfunctional family become so blurred and so engulfed/entangled that it is difficult to understand what role is appropriate for what person and when does the role begin and end, then enmeshment may have taken place. By way of illustration, let us assume that a Native client, "father", has a nine-year-old son who is the only child of a dysfunctional family. The mother has progressed into the late stages of alcoholism. It is logical to assume, during her alcoholic progression, that he has had to perform both roles, "father" and "mother". Now let us further assume, that the "son" becomes the surrogate "wife", supports his father emotionally, and takes over many of his mothers' roles, such as housekeeping and food preparation; but, he also controls access to the home and the control of his mother's true medical condition, constantly feigning excuses for her true problem. The "son" becomes enmeshed", because he doesn't know what role he truly has and where one role starts and the other leaves off. Emotionally, the son may also be incestuously involved with his father and fulfilling much of the emotional support that the father would have normally expected from his wife. The most tragic issue here is that the son was forced to grow up too early, assume adult roles and the normal development needs of a nine-year-old, such as trust, identity, intimacy, and, most importantly, control issue problems related to relationships. Let us now assume that the mother goes into treatment and returns home trying to re-assert her role as "mother". The family, especially the son, may make the following statement: "It was easier to live around here when you were drinking, because everyone knew how to make things work". One more scenario, the father divorces the mother for the second relapse and second failure of treatment and she is no longer living at home. The magical thinking and delusion of her son, now age thirteen, is that she should return, if you will "as is", because he sees the abnormal situation, the dysfunctional, as his only "model" of any family that he knows. This delusion, denial, distortion and dissociation can be so powerful that his magical thinking cannot be bridged, no matter how dysfunctional his mother becomes and he is convinced in his mind that dad and mom will return and everything will be "OK". Remember, these roles that father, mother, and son adjusted to are very rigid and are all "survival roles". Relationally, this son's role has become "enmeshed"

and when he starts dating in high school, he may encounter severe relational difficulties. First, his own image is "low" and what is most unfortunate, is that his family of origin's affect can be so profound as to place in him what Bradshaw describes as a "trance". He may end up with a girl friend who herself is dysfunctional and probably chemically dependent, even though he vowed he would never drink and never get involved with a chemically dependent person. The issue here is that the son's ability for intimacy and identity have become severely compromised. Most of this operates on a unconscious basis and he may attempt to change the person with whom her falls in love, again, because of magical thinking.

STRATEGIES FOR ALLEVIATING DYSFUNCTIONAL ENMESHED CODEPENDENCE

The first step in alleviation of this problem is "awareness" of the new emerging culturally enabling conflictual enmeshmenting codependence. This can be accomplished through a culturally-relevant, educative component which attempts to break through he affected person' "alleged impenetrable denial" and delusion. Remember due to the extent of the extent of the extended family and orientation for kin/kindred/family roles, that for the Native American family, the power of cultural enabling may make the situation more problematic. The videotape by Melody Beattie, titled: "Taking Care of Ourselves", involves a segment portraying a recovering Native American codependent who talks about the changes she has accomplished. Most importantly, treatment must be predicted upon the client's stage of codependence. An interactive group, coupled with a 12-step program and membership in Codep Anonymous, is a suggested strategy after awareness.

It would also appear that a key to recovery for this problem would involve the communication patterns that have been blocked within the family wherein most communication has become either indirect or non-existent. The possibility of "talking circles", guided by a recovering codependent, may also be a necessary adjunct. The key to recovery would involve the entire family "system". All the family should enter an educative and rehabilitative phase of treatment in order to resume communication patterns that have been stunted and broken. Special emphasis would also need to be concentrated on the areas of relapse especially for those re-entering the family those who were chemically dependent. Concentration should include the areas that address previous drinking members of the extended family or clan, all of which may put incredible pressure on the chemically dependent person to resume drinking.

Until some specific Native American-oriented resources are developed, the reader is referred to Tim Cermak's new book titled: Adult Children of Alcoholics, Volume Two: Treatment, (Minneapolis: Johnson Institute's Books, 1991).

AN ETHNOCENTRIC CULTURAL DILEMMA/TEASE

One final issue that needs to be addressed is who is defining this as a problem? In other words, when we look at codependency, we should look at the problem of the cultural context of the problem - how you perceive it is how you define it.

Is it the non-Native Human Service professional population defining it or the Native Human Service professional defining it as codependent behavior? If you didn't realize it was a problem until someone told you it was a problem (awareness of what it is), then is it a problem causing stress? If you don't know what this illness is, do you think you have it (physically and/or emotionally)?

Did traditional environments address how to handle stress? Is codependency directly related to living in a stressful environment? What if the current environment lacks culturally appropriate ways to deal effectively with stress? Rather harmful methods, such as: substance abuse, physical abuse, sexual abuse, smoking, suicide etc., have all been identified. Another factor is the role of stress as it relates to triggering relapse and setting off the post acute withdrawal of clients.

It is important from a cultural context to implement measures to reduce stress from the physical conditions that living in this environment create, especially in the environmentally oppressive environment of an Alaskan winter. Can non-Native stress reduction methods, such as relaxation desensitization, guided imagery, etc., cause even more stress than the original stressor (the chemically dependent person). Can this increase anxiety depression on the codependent Native American. This can be portrayed as follows:

SITUATION	MANAGEMENT	OUTCOME
How perceived in cultural context.	How handled in traditional manner.	Unknown
How perceived in cultural context based on perception of another culture.	Which culture-based management technique used.	Unknown

AN ETHNOCENTRIC CULTURAL DILEMMA

Can a non-traditional stress management technique be as harmful as the situation which created the stress? What are the levels of emotional availability of the extended family units? Where does the person perceive him/herself culturally? Can a non-Native perceive and define this phenomenon for a Native? Can seeking help cause cultural stress? If seeking help is inappropriate within the culture, it can add fuel to the fire.

Another issue is the cultural context of not using verbal skills and how this relates to non-Native treatment approaches of retelling of the past (especially if this is inappropriate within culture as suggested by Harold Napoleon). Another related question is: Can the non-Native culturally perceive what the Native is saying? Can one Native culture correctly perceive another?

The key issue of stunted emotional growth also needs to be addressed in treatment, as it relates to the concept of self-image. At what age do codependent characteristics begin to surface in children? The Native family structure also needs to be compared to the Non-Native. Family communication patterns will have to be ascertained on the basis of the probable entire community milieu. Can the traditional value of enduring suffering in silence be more valuable than ending the pain itself?[13]

CONCLUSION

A revised definition of Post-Traumatic Culture disorder ensues: "PTCD is a re-experiencing of a previous or present value or culture conflict, leading to stress and conflict that culminates into a probable codependent dysfunctional state, with a major emphasis upon loss of identity and boundary/control and relational difficulties."

Cultural enabling is a leading precursor of the problem of dysfunctional codependent behavior which arises from a dysfunctional family system. The lack of witnessing effective parental modeling for those relocated to boarding schools, or those affected by dysfunctional parenting due to chemical dependence, is a key cause of relational difficulties for those affected Native clients. Relocation may be generationally specific, but can be passed on from one generation to the next. The surrogation of traditional family roles is also a key factor in the breakdown of the normal family system. Learned constricted feeling communication matters also serve as key blocks in the development of dysfunctional codependence. The end result may be enmeshed codependent behavior involving a blurring of role assignments and boundaries, which have all resulted from survival role attainment that becomes very dysfunctional. Governmental policies may also foster the development of codependency. The loss and breakdown of communication may be the key to understanding the necessary avenues for treatment, with an emphasis upon talking circles.
In contrasting this phenomenon to middle class interpretation and value patterns, we close with a quote from Vine Deloria, Jr.: Finally, modern American life is comparable to a large and bountiful Christmas tree. It promises only joy and fun, and never suggest a period of doubt when ultimate realities are experienced and understood. Indians are wandering in this plush fantasy desert in the same way as sensitive non-Indians. I will require considerably more thought and significantly less recreation and entertainment before Indians will be able to discern in their own traditions the substance and energy which lies dormant.[14]

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   Indian culture is one of spiritual living in harmony with Nature, a way of life with respect and concern, giving and sharing..."We are a mystical people, believing in equality, living for the present with patience and silence (non-aggressive to our White brother with no apparent awareness of time). The Indian culture provided consistency in love and understanding with honesty. Yes, the Indian lived with individual identity with a feeling of worth which gave him pride..." The Land is called "Mother Earth", the sun is called "Father", and the moon our "Sister", while the rivers and ocean are our witnesses. We believe that water, forest, land and all creatures belong to all, and that they were given as a gift from the Great Spirit as a way of life....(pp 327-328)

   To these alleged Indian values the same authors see the "White values" as diametrically opposed:

   The White man...came looking for religious freedom, yet converting others to his particular religion which seems but a segment of his life. He came with a spirit of competitiveness and a concern for self, saving, acquiring and impatient for wealth, noisy and aggressive... We see you as greedy, destroying Nature, such as land, water, and forests and yet attempting to acquire them as your private domain. We see you as people with their eyes in the future, speeding toward space living and so aware of time that you are missing the beauty of the present.

   In your inconsistency of love and understanding, and by your dishonesty in not giving the Indian equal opportunity for education or employment without prejudice, you have created mistrust. We have lived in your world of dominance and paternalism and have reaped a harvest, created and perpetuated by you, of a poor self-image of ourselves.

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PROJECT CHOICE
OPTIONS FOR YOUNG FAMILIES

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PROJECT CHOICE

OPTIONS FOR YOUNG FAMILIES

RED HORSE LODGE
CROW CREEK RESERVATION

Mimi Olson, Executive Director/Writer
Darlene Medicine Crow, Project Coordinator/Writer
Red Horse Lodge Residents and Patty Leyba, Artists
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Fall, 1990

With Special Thanks to the Bush Foundation, St. Paul, Minnesota

PROJECT CHOICE - OPTIONS FOR YOUNG FAMILIES

Mimi Olson
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Crow Creek Reservation is a small reservation located in central South Dakota. Red Horse Lodge is located in Ft. Thompson, the central district of the Crow Creek Reservation. Red Horse Lodge was established in 1980 to serve Indian families in need, primarily families from the Crow Creek Indian Reservation. As Red Horse Lodge programs developed, services were expanded to include youth and families from other reservations in the area.

Primary programs of Red Horse Lodge now include:

1. An adolescent residential treatment program for emotionally-disturbed youth.
2. A Title II Indian Child Welfare Program that works with family preservation and reunification.
3. A domestic violence shelter for women and children who are victims of domestic violence and sexual assault.
4. A victims' advocacy program for victims of sexual abuse.
5. Options counseling and curriculum development for teen mothers.

Every year on the Crow Creek Indian Reservation there are tremendous numbers of teenage pregnancies reported. Many of these girls are so overwhelmed with the problems related to pregnancy that they are at high risk of denial of pregnancy, resulting in either poor or even no prenatal care, dropping out of school, trying to commit suicide, giving birth to Fetal Alcohol babies, suffering from domestic abuse, and experiencing other dysfunctional lifestyles. These teen parents are also at high risk of abusing or neglecting their own children unless intervention is made early in pregnancy/parenthood, and/or the options available for not becoming pregnant are exercised.

Throughout the last two years, Red Horse Lodge Project Choice has provided classes, group sessions, and counseling to 177 teen parents. These classes and groups have developed into cohesive, supportive groups of young people. They are committed to continuing their groups and are working on supporting each other throughout their parenting years. This program has proven to be conducive to the groups' bonding processes as well as to providing educational services and reducing the number of incidents of abuse/neglect, domestic violence, and self-destructive behaviors. These groups need to continue of their own volition as well as to expand to include new teen mothers and clients in the program.

The issues of sexuality, responsibility, and pregnancy prevention are addressed with teenagers. During the year the Options Counselor, who works with the domestic violence program, recruits and teaches teen mothers and other interested young people, and utilizes the teen mothers who have completed the program as volunteers to assist in classes and groups.

The project was originally funded by the Bush Foundation of St. Paul, Minnesota. Funds were used to provide the salary for the counselor and to develop the curriculum. Stipends for the participants who attended classes and groups were paid by the State's Children's Trust Fund. The Program continues to be funded by the Dakota Indian Foundation of Chamberlain, South Dakota and the United Church Board of Ministries of New York City.

In 1989 at least 62 teenage girls were identified as being pregnant or having a child on the Crow Creek Reservation. The drop-out rate is believed to have decreased but not to a measurable extent.

- At the beginning of the 1990 school year, there were 6 known pregnancies in Crow Creek Reservation High School.

- In 1988 50% of all births on the Crow Creek Reservation were to teenage girls. Their youth coupled with the lack of a support system in their lives, may lead to child abuse and neglect.

- 95% of teen parents are unmarried or single parents and, thus, must assume parenting duties of both father and mother.

- 100% of teen parents who have been involved in the teen parent program at Red Horse Lodge live below the poverty line.

- Teen parents are accustomed to seeing child abuse and neglect in the community. Up to 20% of reservation children are removed from their families for some length of time to protect them from child abuse and neglect.

- Alcohol and drug abuse, which is linked with nearly all child abuse and neglect cases, is an accepted life style in the community. 95% of reservation youth abuse alcohol or drugs or have close family members who are chemically addicted.

The project plans to continue to improve and expand its teen parent component, called "Project Choice", by offering specialized classes to groups of teen mothers in order to expand their awareness and knowledge about such issues as parenting, appropriate discipline, self-esteem, child abuse/neglect, self-help groups, domestic violence, alcohol and drugs, and to develop groups of young women who are supportive to each other as they continue in school, develop relationships, and meet personal goals.

The Options Counselor conducts three educational counseling cycles a year. Each cycle lasts for fifteen weeks. During each of the fifteen weeks of the cycle, there is one education class session of two hours, one hour of peer support group counseling, and one hour of individualized, intensive options counseling. In each cycle, up to eight teen mothers, 14 pregnant or at-risk youth, and teen fathers may participate. Each teen mom receives an incentive stipend of $10 a week, if she participates in all three scheduled activities. Expectant parents and those youth at-risk who participate receive $50 at the end of each successfully completed cycle. All participants must complete each scheduled activity in the cycle in order to be eligible for the stipend. During each cycle two participants, who have completed the course and show an interest and ability, are chosen to train as facilitators of groups and to lead the education classes. This creates an interest to continue the groups and provides the incentive for the young people of the community to "take ownership" of the program. These young teens are paid the incentive for participation during one cycle.

Extra-curricular activities include fund-raising activities so that each cycle class will have sufficient money to have one big baby shower for all the expectant moms or attend a symposium or workshop of their choice.

The Options Counselor holds a degree in Human Services and has many years of experience working with teens, both in program/teaching settings and at home.

CYCLES I, II AND III

WEEK ONE:
Introduction and Pre-Test

WEEK TWO:
Body Awareness and STD's

WEEK THREE:
Self-Esteem (Self-esteem and assertiveness continues throughout all cycles)

WEEK FOUR:
Pre-Natal Care and Nutrition

WEEK FIVE:
Fetal Alcohol Syndrome Prevention and Alcoholism

WEEKS SIX, SEVEN, AND EIGHT:
Teenage Parenting

WEEK NINE:
Post-Natal Care

WEEK TEN:
Community Resources

WEEK ELEVEN:
Child Abuse/Neglect
Domestic Violence

WEEK TWELVE:
Birth Control and Family Planning
Decision-making
Post-Test

Referrals are accepted from Social Services, Crow Creek High School, Indian Health Service, Bureau of Indian Affairs, Tribal agencies, and various local concerned people. As this program has progressed during these two years, the referrals have been coming in on an ever-increasing scale. Information pamphlets are distributed and in-services are held throughout the year in order to inform the community of the program, its progress, and to reach teens in the community. Referral forms are distributed throughout the community to appropriate agencies and programs. Intensive recruitment is held beginning at least two weeks before each cycle and visits are made to each service agency to remind them of program services offered. Follow-up is conducted at least two weeks after each cycle to determine whether or not any of the participants need additional help in any particular area. They are eligible to receive counseling on an individual basis, if needed. Informal educational classes are also conducted outside of the cycles based on need.

Evaluations are determined by: the pre- and post-test results which determine how much participants were able to learn; progress reports of individualized options counseling sessions by the Options Counselor; and project evaluations completed by the participants at the end of each cycle. Cooperating agencies are also given evaluation forms so that they can evaluate project effectiveness.

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RECENT CHILD ABUSE & MENTAL HEALTH LEGISLATION AFFECTING NATIVE AMERICAN/ALASKAN NATIVES

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SUMMARY

WORKSHOP

CHILD ABUSE LEGISLATION: Public Law 101-630

Title IV of Public Law (PL) 101-630, Indian Child Protection, is Federal legislation dealing with child abuse on Indian reservations.[1] The Sections in this law are as follows:

Section	401	Short Title
	402	Findings and Purpose
	403	Definitions
	404	Reporting Procedures
	405	Central Registry
	406	Confidentiality
	407	Waiver of Parental Consent
	408	Character Investigations
	409	Indian Child Abuse Treatment Program
	410	Indian Child Resource and Family Services Centers
	411	Indian Child Protection and Family Violence Prevention Program
	412	Report

Section 401. Short Title

This legislation resulted from merging two bills, S. 1783 and S. 2340 and is titled, "Indian Child Protection and Family Violence Prevention Act".

Section 402. Findings and Purpose

The legislation cites a variety of reasons for assuming a high incidence of child abuse on Indian reservations. These reasons include under-reporting due to the lack of a Federal law which mandates reporting, to incidents of child sexual abuse perpetrated by Federal employees or employees funded with Federal funds who were not appropriately investigated prior to employment, and to insufficient funds for treatment services.

In light of these deficiencies, the legislation declares two major goals: identify the scope and reduce the incidents of child abuse and family violence; provide funds for treatment of Indian victims of child abuse and family violence.

The purpose of the legislation is essentially to correct the deficiencies through improved reporting, establishment of a data base, provision of technical assistance, and establishment of treatment and prevention Tribal grant programs.

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[1]A copy of Title IV is attached.

Section 403. Definitions

Of particular importance this section provides definitions of child abuse(including sexual abuse), child neglect, and family violence.

Section 404. Reporting Procedures

This section gives an extensive list of professionals (human service workers, teachers, administrators and law enforcement officials) who are mandated to report suspected child abuse. Failure to report or interference with reporting may result in a fine and/or prison. Suspected child abuse reports are to be made to the "local law enforcement agency" and the "local child protective agency", meaning Federal, State or Tribal agencies primarily responsible for child protection. The section goes on to specify the time frames for handling reports of child abuse.

Section 405. Central Registry

Earlier bills leading to this legislation required the establishment of a central register. Because of due process concerns and lack of clarity on the location and purpose of a central register, the legislation was written to require a study on the feasibility of a central register. The BIA is responsible for conducting the study in consultation with the IHS and the Attorney General.

Section 406. Confidentiality

This section provides for confidential exchange of information and records between Federal and Tribal entities which will enhance the investigation and treatment of children who were abused.

Section 407. Waiver of Parental Consent

In cases of suspected child abuse examinations and interviews medical and psychological professionals and interviews by law enforcement and child protection officials are permitted without parental consent under the authority of this law.

Section 408. Character Investigations

This section requires the IHS and the BIA to compile a list of positions which involve regular contact with children and to conduct background investigations on persons being considered for these positions. The purpose of these investigations is to look for possible sexual abuse offenders before they are employed. Furthermore, this section also requires Federally funded Tribal programs to conduct similar background investigations on potential employees.

Section 409. Indian Child Abuse Treatment Grant Program

This program is administered by the IHS and will provide grants to Tribes for treatment of victims of child sexual abuse. Maximum authority for any grant is $500,000 and the total funding authority is $10,000,000 for each of fiscal years 1992, 1993, 1994, and 1995. These funds have not been appropriated.

Section 410. Indian Child Resource and Family Services Centers

The law requires the BIA to establish an Indian Child Resource and Family Services Center in each Area. The staffing of these centers is specified in this section and is to include BIA and IHS professionals. The staffing and operation of the centers will be coordinated through an interagency agreement between the BIA and the IHS and will receive advice and assistance from an Advisory Board of Tribal members and human service providers. Only $3,000,000 for each of the fiscal years 1992, 1993, 1994 and 1995 are authorized. These funds have not been appropriated.

Section 411. Indian Child Protection and Family Violence Prevention Program

The Indian Child Protection and Family Violence Prevention Program will be administered by the BIA. This program provides grants to Tribes for child abuse and family violence treatment and prevention programs. The grants may pay for shelters, staff, training, equipment and a variety of other things, which may be required in the development of Tribal multidisciplinary programs. The provisions in this section are quite extensive and have considerable potential in improving Tribal child protection and family violence services. The amount authorized under this section is $30,000,000 for each of the fiscal years 1992,1993, 1994 and 1995. Funds have not been appropriated.

Section 412. Report

A yearly report on the administration of Title IV must be submitted to Congress by BIA.

H.R. 3703

Pub. L. 101-630
104 Stat. 4531
Act of 11/28/90

OFFICE OF THE SECRETARY
90 NOV 16 AM 10:
OFFICE OF CONGRESSIONAL & LEGISLATIVE AFFAIRS

One Hundred First Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the twenty-third day of January, one thousand nine hundred and ninety

An Act

To authorize the Rumsey Indian Rancheria to convey a certain parcel of land.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—RUMSEY INDIAN RANCHERIA

TITLE II—MILLE LACS INDIAN RESERVATION LEASE

SEC. 241. MILLE LACS INDIAN RESERVATION LEASE TO MINNESOTA STATE HISTORICAL SOCIETY.

TITLE III—INDIAN FOREST AND WOODLANDS

TITLE IV—INDIAN CHILD PROTECTION

SEC. 401. SHORT TITLE.

This title may be cited as the "Indian Child Protection and Family Violence Prevention Act".

SEC. 402. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress, after careful review of the problem of child abuse on Indian reservations and the historical and special relationship of the Federal Government with Indian people,

(1) finds that—

(A) incidents of abuse of children on Indian reservations are grossly underreported;

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(B) such underreporting is often a result of the lack of a mandatory Federal reporting law;

(C) multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by persons employed or funded by the Federal Government;

(D) Federal Government investigations of the background of Federal employees who care for, or teach, Indian children are often deficient;

(E) funds spent by the United States on Indian reservations or otherwise spent for the benefit of Indians who are victims of child abuse or family violence are inadequate to meet the growing needs for mental health treatment and counseling for victims of child abuse or family violence and their families; and

(F) there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and the United States has a direct interest, as trustee, in protecting Indian children who are members of, or are eligible for membership in, an Indian tribe; and

(2) declares that two major goals of the United States are to—

(A) identify the scope of incidents of abuse of children and family violence in Indian country and to reduce such incidents; and

(B) provide funds for mental health treatment for Indian victims of child abuse and family violence on Indian reservations.

(b) PURPOSE.—The purposes of this title are to—

(1) require that reports of abused Indian children are made to the appropriate authorities in an effort to prevent further abuse;

(2) establish a reliable data base for statistical purposes and to authorize a study to determine the need for a central registry for reported incidents of abuse;

(3) authorize such other actions as are necessary to ensure effective child protection in Indian country;

(4) establish the Indian Child Abuse Prevention and Treatment Grant Program to provide funds for the establishment on Indian reservations of treatment programs for victims of child sexual abuse;

(5) provide for technical assistance and training related to the investigation and treatment of cases of child abuse and neglect;

(6) establish Indian Child Resource and Family Services Centers in each Bureau of Indian Affairs Area Office which will consist of multi-disciplinary teams of personnel with experience and training in the prevention, identification, investigation, and treatment of child abuse and neglect;

(7) provide for the treatment and prevention of incidents of family violence;

(8) establish tribally operated programs to protect Indian children and reduce the incidents of family violence in Indian country; and

(9) authorize other actions necessary to ensure effective child protection on Indian reservations.

SEC. 402. DEFINITIONS.

For the purposes of this title, the term—

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(1) "Bureau" means the Bureau of Indian Affairs of the Department of the Interior;

(2) "child" means an individual who—

(A) is not married, and

(B) has not attained 18 years of age;

(3) "child abuse" includes but is not limited to—

(A) any case in which—

(i) a child is dead or exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, and

(ii) such condition is not justifiably explained or may not be the product of an accidental occurrence; and

(B) any case in which a child is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution;

(4) "child neglect" includes but is not limited to, negligent treatment or maltreatment of a child by a person, including a person responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened thereby;

(5) "family violence" means any act, or threatened act, of violence, including any forceful detention of an individual, which—

(A) results, or threatens to result, in physical or mental injury, and

(B) is committed by an individual against another individual—

(i) to whom such person is, or was, related by blood or marriage or otherwise legally related, or

(ii) with whom such person is, or was, residing;

(6) "Indian" means any individual who is a member of an Indian tribe;

(7) "Indian child" has the meaning given to such term by section 4(4) of the Indian Child Welfare Act of 1978 (25 U.S.C. 1903(4));

(8) "Indian country" has the meaning given to such term by section 1151 of title 18, United States Code;

(9) "Indian reservation" means any Indian reservation, public domain Indian allotment, former Indian reservation in Oklahoma, or lands held by incorporated Native groups, regional corporations, or village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.);

(10) "Indian tribe" and "tribal organization" have the respective meanings given to each of such terms under section 4 of the Indian Self Determination and Education Assistance Act (25 U.S.C. 450b);

(11) "inter-tribal consortium" means a partnership between—

(A) an Indian tribe or tribal organization of an Indian tribe, and

(B) one or more Indian tribes or tribal organizations of one or more other Indian tribes;

(12) "local child protective services agency" means that agency of the Federal Government, of a State, or of an Indian tribe that has the primary responsibility for child protection on any Indian reservation or within any community in Indian country;

(13) "local law enforcement agency" means that Federal, tribal, or State law enforcement agency that has the primary responsibility for the investigation of an instance of alleged child abuse within the portion of Indian country involved;

(14) "persons responsible for a child's welfare" means any person who has legal or other recognized duty for the care and safety of a child, including—

(A) any employee or volunteer of a children's residential facility, and

(B) any person providing out-of-home care, education, or services to children;

(15) "related assistance"—

(A) includes counseling and self-help services to abusers, victims, and dependents in family violence situations (which shall include counseling of all family members to the extent feasible) and referrals for appropriate health-care services (including alcohol and drug abuse treatment), and

(B) may include food, clothing, child care, transportation, and emergency services for victims of family violence and their dependents;

(16) "Secretary" means the Secretary of the Interior;

(17) "shelter" means the provision of temporary refuge and related assistance in compliance with applicable Federal and tribal laws and regulations governing the provision, on a regular basis, of shelter, safe homes, meals, and related assistance to victims of family violence or their dependents; and

(18) "Service" means the Indian Health Service of the Department of Health and Human Services.

SEC. 404. REPORTING PROCEDURES.

(a) REPORT TO LOCAL LAW ENFORCEMENT AGENCY.—(1) Chapter 53 of title 18, United States Code, is amended by adding at the end thereof the following new section:

"§ 1169. Reporting of child abuse

"(a) Any person who—

"(1) is a—

"(A) physician, surgeon, dentist, podiatrist, chiropractor, nurse, dental hygienist, optometrist, medical examiner, emergency medical technician, paramedic, or health care provider,

"(B) teacher, school counselor, instructional aide, teacher's aide, teacher's assistant, or bus driver employed by any tribal, Federal, public or private school,

"(C) administrative officer, supervisor of child welfare and attendance, or truancy officer of any tribal, Federal, public or private school,

"(D) child day care worker, headstart teacher, public assistance worker, worker in a group home or residential or day care facility, or social worker,

"(E) psychiatrist, psychologist, or psychological assistant,

"(F) licensed or unlicensed marriage, family, or child counselor,

"(G) person employed in the mental health profession, or

"(H) law enforcement officer, probation officer, worker in a juvenile rehabilitation or detention facility, or person

employed in a public agency who is responsible for enforcing statutes and judicial orders;

"(2) knows, or has reasonable suspicion, that—

"(A) a child was abused in Indian country, or

"(B) actions are being taken, or are going to be taken, that would reasonably be expected to result in abuse of a child in Indian country; and

"(3) fails to immediately report such abuse or actions described in paragraph (2) to the local child protective services agency or local law enforcement agency,

shall be fined not more than $5,000 or imprisoned for not more than 6 months or both.

"(b) Any person who—

"(1) supervises, or has authority over, a person described in subsection (a)(1), and

"(2) inhibits or prevents that person from making the report described in subsection (a),

shall be fined not more than $5,000 or imprisoned for not more than 6 months or both.

"(c) For purposes of this section, the term—

"(1) 'abuse' includes—

"(A) any case in which—

"(i) a child is dead or exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, and

"(ii) such condition is not justifiably explained or may not be the product of an accidental occurrence; and

"(B) any case in which a child is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution;

"(2) 'child' means an individual who—

"(A) is not married, and

"(B) has not attained 18 years of age;

"(3) 'local child protective services agency' means that agency of the Federal Government, of a State, or of an Indian tribe that has the primary responsibility for child protection on any Indian reservation or within any community in Indian country; and

"(4) 'local law enforcement agency' means that Federal, tribal, or State law enforcement agency that has the primary responsibility for the investigation of an instance of alleged child abuse within the portion of Indian country involved.

"(d) Any person making a report described in subsection (a) which is based upon their reasonable belief and which is made in good faith shall be immune from civil or criminal liability for making that report.".

(2) The table of contents for chapter 53 of title 18, United States Code, is amended by adding at the end thereof the following new item:

"1169. Reporting of child abuse.".

(b) NOTIFICATION OF CHILD ABUSE REPORTS.—(1) When a local law enforcement agency or local child protective services agency receives an initial report from any person of—

(A) the abuse of a child in Indian country, or

(B) actions which would reasonably be expected to result in abuse of a child in Indian country, the receiving agency shall immediately notify appropriate officials of the other agency of such report and shall also submit, when prepared, a copy of the written report required under subsection (c) to such agency.

(2) Where a report of abuse involves an Indian child or where the alleged abuser is an Indian and where a preliminary inquiry indicates a criminal violation has occurred, the local law enforcement agency, if other than the Federal Bureau of Investigation, shall immediately report such occurrence to the Federal Bureau of Investigation.

(c) WRITTEN REPORT OF CHILD ABUSE.—(1) Within 36 hours after receiving an initial report described in subsection (b), the receiving agency shall prepare a written report which shall include, if available—

(A) the name, address, age, and sex of the child that is the subject of the report;

(B) the grade and the school in which the child is currently enrolled;

(C) the name and address of the child's parents or other person responsible for the child's care;

(D) the name and address of the alleged offender;

(E) the name and address of the person who made the report to the agency;

(F) a brief narrative as to the nature and extent of the child's injuries, including any previously known or suspected abuse of the child or the child's siblings and the suspected date of the abuse; and

(G) any other information the agency or the person who made the report to the agency believes to be important to the investigation and disposition of the alleged abuse.

(2)(A) Any local law enforcement agency or local child protective services agency that receives a report alleging abuse described in section 503(3) shall immediately initiate an investigation of such allegation and shall take immediate, appropriate steps to secure the safety and well-being of the child or children involved.

(B) Upon completion of the investigation of any report of alleged abuse that is made to a local law enforcement agency or local child protective services agency, such agency shall prepare a final written report on such allegation.

(d) CONFIDENTIALITY OF INFORMANT.—The identity of any person making a report described in subsection (b)(1) shall not be disclosed, without the consent of the individual, to any person other than a court of competent jurisdiction or an employee of an Indian tribe, a State or the Federal Government who needs to know the information in the performance of such employee's duties.

SEC. 404. CENTRAL REGISTRY.

(a) PREPARATION OF STUDY.—The Secretary, in consultation with the Secretary of Health and Human Services and the Attorney General of the United States, is hereby authorized and directed to prepare a written study on the feasibility of, and need for, the establishment of a Central Register for reports or information on the abuse of children in Indian country.

(b) CONTENT OF STUDY.—The study conducted pursuant to subsection (a) shall include, but shall not be limited to—

(1) the need for, and purpose of, a Central Register;

(2) the examination of due process implication of the maintenance of such a register;

(3) the extension of access to information contained in the register;

(4) the need and process for expunging information from the register;

(5) the types, and duration of maintenance, of information in the register; and

(6) the classes of persons who should be covered by such register.

(c) The Secretary shall complete the study conducted pursuant to this section and shall submit such study, together with recommendations and draft legislation to implement such recommendations, to the Congress within 180 days after the date of enactment of this title.

SEC. 404. CONFIDENTIALITY.

Pursuant to section 552a of title 5, United States Code, the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. 1232g), or any other provision of law, agencies of any Indian tribe, of any State, or of the Federal Government that investigate and treat incidents of abuse of children may provide information and records to those agencies of any Indian tribe, any State, or the Federal Government that need to know the information in performance of their duties. For purposes of this section, Indian tribal governments shall be treated the same as other Federal Government entities.

SEC. 407. WAIVER OF PARENTAL CONSENT.

(a) EXAMINATIONS AND INTERVIEWS.—Photographs, x-rays, medical examinations, psychological examinations, and interviews of an Indian child alleged to have been subject to abuse in Indian country shall be allowed without parental consent if local child protective services or local law enforcement officials have reason to believe the child has been subject to abuse.

(b) INTERVIEWS BY LAW ENFORCEMENT AND CHILD PROTECTIVE SERVICES OFFICIALS.—In any case in which officials of the local law enforcement agency or local child protective services agency have reason to believe that an Indian child has been subject to abuse in Indian country, the officials of those agencies shall be allowed to interview the child without first obtaining the consent of the parent, guardian, or legal custodian.

(c) PROTECTION OF CHILD.—Examinations and interviews of a child who may have been the subject of abuse shall be conducted under such circumstances and with such safeguards as are designed to minimize additional trauma to the child and, where time permits, shall be conducted with the advise, or under the guidance, of a local multidisciplinary team established pursuant to section 411 or, in the absence of a local team, a multidisciplinary team established pursuant to section 410.

(d) COURT ORDERS.—Upon a finding of reasonable suspicion that an Indian child has been the subject of abuse in Indian country, a Federal magistrate or United States District Court may issue an order enforcing any provision of this section.

SEC. 408. CHARACTER INVESTIGATIONS.

(a) BY SECRETARY OF THE INTERIOR AND THE SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary and the Secretary of Health and Human Services shall—

(1) compile a list of all authorized positions within their respective departments the duties and responsibilities of which involve regular contact with, or control over, Indian children,

(2) conduct an investigation of the character of each individual who is employed, or is being considered for employment, by the respective Secretary in a position listed pursuant to paragraph (1), and

(3) prescribe by regulations minimum standards of character that each of such individuals must meet to be appointed to such positions.

(b) CRIMINAL RECORDS.—The minimum standards of character that are to be prescribed under this section shall ensure that none of the individuals appointed to positions described in subsection (a) have been found guilty of, or entered a plea of nolo contendere or guilty to, any offense under Federal, State, or tribal law involving crimes of violence; sexual assault, molestation, exploitation, contact or prostitution; or crimes against persons.

(c) INVESTIGATIONS BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Each Indian tribe or tribal organization that receives funds under the Indian Self-Determination and Education Assistance Act or the Tribally Controlled Schools Act of 1988 shall—

(1) conduct an investigation of the character of each individual who is employed, or is being considered for employment, by such tribe or tribal organization in a position that involves regular contact with, or control over, Indian children, and

(2) employ individuals in those positions only if the individuals meet standards of character, no less stringent than those prescribed under subsection (a), as the Indian tribe or tribal organization shall establish.

SEC. 409. INDIAN CHILD ABUSE TREATMENT GRANT PROGRAM.

(a) ESTABLISHMENT OF GRANT PROGRAM.—The Secretary of Health and Human Services, acting through the Service and in cooperation with the Bureau, shall establish an Indian Child Abuse Treatment Grant Program that provides grants to any Indian tribe or intertribal consortium for the establishment on Indian reservations of treatment programs for Indians who have been victims of child sexual abuse.

(b) GRANT APPLICATIONS.—(1) Any Indian tribe or intertribal consortium may submit to the Secretary of Health and Human Services an application for a grant under subsection (a).

(2) Any application submitted under paragraph (1)—

(A) shall be in such form as the Secretary of Health and Human Services may prescribe;

(B) shall be submitted to such Secretary on or before the date designated by such Secretary; and

(C) shall specify—

(i) the nature of the program proposed by the applicant,

(ii) the data and information on which the program is based,

(iii) the extent to which the program plans to use or incorporate existing services available on the reservation, and

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(iv) the specific treatment concepts to be used under the program.

(c) MAXIMUM GRANT AMOUNT.—The maximum amount of any grant awarded under subsection (a) shall not exceed $500,000.

(d) GRANT ADMINISTRATION AND FINAL REPORT.—Each recipient of a grant awarded under subsection (a) shall—

(1) furnish the Secretary of Health and Human Services with such information as such Secretary may require to—

(A) evaluate the program for which the grant is made, and

(B) ensure that the grant funds are expended for the purposes for which the grant was made, and

(2) submit to such Secretary at the close of the term of the grant a final report which shall include such information as the Secretary may require.

(e) there is hereby authorized to be appropriated to carry out the provisions of this section $10,000,000 for each of the fiscal years 1992, 1993, 1994, and 1995.

SEC. 416. INDIAN CHILD RESOURCE AND FAMILY SERVICES CENTERS.

(a) ESTABLISHMENT.—The Secretary shall establish within each area office of the Bureau an Indian Child Resource and Family Services Center.

(b) MEMORANDUM OF AGREEMENT.—The Secretary and the Secretary of Health and Human Services shall enter into a Memorandum of Agreement which provides for the staffing of the Centers established under this section.

(c) CENTER STAFFING.—Each Center established under subsection (a) shall be staffed by a multidisciplinary team of personnel with experience and training in prevention, identification, investigation, and treatment of incidents of family violence, child abuse, and child neglect.

(d) CENTER RESPONSIBILITIES AND FUNCTIONS.—Each Center established under subsection (a) shall—

(1) provide advice, technical assistance, and consultation to Indian tribes, tribal organizations, and inter-tribal consortia upon request;

(2) provide training to appropriate personnel of Indian tribes, tribal organizations, the Bureau and the Service on the identification and investigation of cases of family violence, child abuse, and child neglect and, to the extent practicable, coordinate with institutions of higher education, including tribally controlled community colleges, to offer college-level credit to interested trainees;

(3) develop training materials on the prevention, identification, investigation, and treatment of incidents of family violence, child abuse, and child neglect for distribution to Indian tribes and to tribal organizations;

(4) develop recommendations to assist Federal and tribal personnel to respond to cases of family violence, child abuse, and child neglect; and

(5) develop policies and procedures for each agency office of the Bureau and service unit of the Service within the area which, to the extent feasible, comply with tribal laws pertaining to cases of family violence, child abuse, and child neglect, including any criminal laws, and which provide for maximum cooperation with the enforcement of such laws.

(e) MULTIDISCIPLINARY TEAM PERSONNEL.—Each multidisciplinary team established under this section shall include, but is not limited to, personnel with a background in—

(1) law enforcement,

(2) child protective services,

(3) juvenile counseling and adolescent mental health, and

(4) domestic violence.

3 staff at each Area Office

(f) CENTER ADVISORY BOARD.—The Secretary, in consultation with the Secretary of Health and Human Services, shall establish, for each Indian Child Resource and Family Services Center, an advisory board to advise and assist such Center in carrying out its activities under this Act. Each advisory board shall consist of 7 members appointed by the Secretary from Indian tribes and human service providers served by an area office of the Bureau. Members shall serve without compensation, but may be reimbursed for travel and other expenses while carrying out the duties of the board. The advisory board shall assist the Center in coordinating programs, identifying training materials, and developing policies and procedures relating to family violence, child abuse, and child neglect.

(g) APPLICATION OF THE INDIAN SELF-DETERMINATION ACT TO CENTERS.—Indian Child Resource and Family Services Centers established under subsection (a) shall be subject to the provisions of the Indian Self-Determination Act. If a Center is located in an area office of the Bureau which serves more than one Indian tribe, any application to enter into a contract to operate the Center pursuant to such Act must have the consent of each of the other tribes to be served under the contract, except that, in the Juneau Area, only the consent of such tribes or tribal consortia that are engaged in contracting of Indian Child Protection and Family Violence Prevention programs pursuant to such Act shall be required. This section shall not preclude the designation of an existing child resource and family services center operated by a tribe or tribal organization as a Center if all of the tribes to be served by the Center agree to such designation.

(h) APPROPRIATIONS.—There are authorized to be appropriated to carry out the provisions of this section $3,000,000 for each of the fiscal years 1992, 1993, 1994, and 1995.

SEC. 411. INDIAN CHILD PROTECTION AND FAMILY VIOLENCE PREVENTION PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish within the Bureau an Indian Child Protection and Family Violence Prevention Program to provide financial assistance to any Indian tribe, tribal organization, or inter-tribal consortium for the development of an Indian Child Protection and Family Violence Prevention program.

(b) INDIAN SELF-DETERMINATION ACT AGREEMENTS.—The Secretary is authorized to enter into agreements with Indian tribes, tribal organizations, or inter-tribal consortia pursuant to the Indian Self-Determination Act for the establishment of Indian Child Protection and Family Violence Prevention programs on Indian reservations.

(c) INVESTIGATION AND TREATMENT AND PREVENTION OF CHILD ABUSE AND FAMILY VIOLENCE.—An Indian tribe operating an Indian Child Protection and Family Violence Prevention program established under this section shall designate the agency or officials which shall be responsible—

(1) for the investigation of reported cases of child abuse and child neglect; and

(2) for the treatment and prevention of incidents of family violence; and

(3) for the provision of immediate shelter and related assistance for victims of family violence and their dependents.

(d) PROGRAM RESPONSIBILITIES AND FUNCTIONS.—Funds provided pursuant to this section may be used for—

(1) the establishment of a child protective services program which may include—

(A) the employment of child protective services staff to investigate cases of child abuse and child neglect,

(B) training programs for child protective services personnel, law enforcement personnel, and judicial personnel in the investigation, prevention, and treatment of cases of child abuse and child neglect, and

(C) purchase of equipment to assist in the investigation of cases of child abuse and child neglect;

(2) the establishment of a family violence prevention and treatment program which may include—

(A) the employment of family violence prevention and treatment staff to respond to incidents of family violence,

(B) the provision of immediate shelter and related assistance for victims of family violence and their dependents,

(C) training programs for family violence prevention and treatment personnel, law enforcement personnel, and judicial personnel in the investigation, prevention, and treatment of cases of family violence; and

(D) construction or renovation of facilities for the establishment of family violence shelters;

(3) the development and implementation of a multidisciplinary child abuse investigation and prosecution program which may—

(A) coordinate child abuse prevention, investigation, prosecution, treatment, and counseling services,

(B) develop protocols among related agencies to ensure that investigations of child abuse cases, to the extent practicable, minimize the trauma to the child victim, and

(C) provide for the coordination and cooperation of law enforcement agencies, courts of competent jurisdiction, and other tribal, Federal, and State agencies through intergovernmental or interagency agreements that define and specify each party's responsibilities;

(4) the development of tribal child protection codes and regulations;

(5) the establishment of training programs for—

(A) professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of prevention, identification, investigation, and treatment of family violence, child abuse, and child neglect,

(B) instruction in methods of protecting children from abuse and neglect for persons responsible for the welfare of Indian children, including parents of, and persons who work with, Indian children, or

(C) educational, identification, prevention and treatment services for child abuse and child neglect in cooperation

with preschool, elementary and secondary schools, or tribally controlled community colleges (within the meaning of section 2 of the Tribally Controlled Community College Act of 1978 (25 U.S.C. 1801));

(6) other community education efforts for tribal members (including school children) regarding issues of family violence, child abuse, and child neglect; and

(7) such other innovative and culturally relevant programs and projects as the Secretary may approve, including programs and projects for—

(A) parental awareness and self-help,

(B) prevention and treatment of alcohol and drug-related family violence, child abuse, and child neglect, or

(C) home health visitor programs,

that show promise of successfully preventing and treating cases of family violence, child abuse, and child neglect.

(f) SECRETARIAL REGULATIONS; BASE SUPPORT FUNDING.—(1) The Secretary, with the participation of Indian tribes, shall establish, and promulgate by regulations, a formula which establishes base support funding for Indian Child Protection and Family Violence Prevention programs.

(2) In the development of regulations for base support funding for such programs, the Secretary shall develop, in consultation with Indian tribes, appropriate caseload standards and staffing requirements which are comparable to standards developed by the National Association of Social Work, the Child Welfare League of America and other professional associations in the field of social work and child welfare. Each level of funding assistance shall correspond to the staffing requirements established by the Secretary pursuant to this section.

(3) Factors to be considered in the development of the base support funding formula shall include, but are not limited to—

(A) projected service population of the program;

(B) projected service area of the program;

(C) projected number of cases per month; and

(D) special circumstances warranting additional program resources, such as high incidence of child sexual abuse, high incidence of violent crimes against women, or the existence of a significant victim population within the community.

(4) The formula established pursuant to this subsection shall provide funding necessary to support—

(A) one child protective services or family violence caseworker, including fringe benefits and support costs, for each tribe; and

(B) an additional child protective services and family violence caseworker, including fringe benefits and support costs, for each level of assistance for which an Indian tribe qualifies.

(5) In any fiscal year that appropriations are not sufficient to fully fund Indian Child Protection and Family Violence Prevention programs at each level of assistance under the formula required to be established in this subsection, available funds for each level of assistance shall be evenly divided among the tribes qualifying for that level of assistance.

(g) MAINTENANCE OF EFFORT.—Services provided under contracts made under this section shall supplement, not supplant, services from any other funds available for the same general purposes, including, but not limited to—

(1) treatment, including, but not limited to—
(A) individual counseling,
(B) group counseling, and
(C) family counseling;
(2) social services and case management;
(3) training available to Indian tribes, tribal agencies, and Indian organizations regarding the identification, investigation, prevention, and treatment of family violence, child abuse, and child neglect; and
(4) law enforcement services, including investigations and prosecutions.

(h) CONTRACT EVALUATION AND ANNUAL REPORT.—Each recipient of funds awarded pursuant to subsection (a) shall—
(1) furnish the Secretary with such information as the Secretary may require to—
(A) evaluate the program for which the award is made, and
(B) ensure that funds are expended for the purposes for which the award was made; and
(2) submit to the Secretary at the end of each fiscal year an annual report which shall include such information as the Secretary may require.

(i) APPROPRIATIONS.—There are authorized to be appropriated to carry out the provisions of this section $30,000,000 for each of the fiscal years 1992, 1993, 1994, and 1995.

SEC. 412. REPORT.

On or before March 1, 1991, and March 1 of each calendar year thereafter, the Secretary shall submit to the Congress a report involving the administration of this title during the calendar year preceding the calendar year in which such report is submitted.

TITLE V—INDIAN HEALTH CARE

SEC. 501. SHORT TITLE.

This title may be cited as the "Indian Health Care Amendments of 1990".

SEC. 502. REFERENCES.

Except as may otherwise be specifically provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 503. MENTAL HEALTH PREVENTION AND TREATMENT SERVICES.

(a) PURPOSES.—The purposes of this section are to—
(1) authorize and direct the Indian Health Service to develop a comprehensive mental health prevention and treatment program;
(2) provide direction and guidance relating to mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and

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SOARING EAGLES PREVENTION PROJECT

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SOARING EAGLES PREVENTION PROJECT

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INTRODUCTION

The Soaring Eagles Prevention Project is a multi-faceted program designed to prevent alcohol and substance abuse and to promote healthy lifestyles and a positive support network for American Indian youth. Members reside in the Minneapolis/St. Paul metro area, and range in age from 3-20. The project is currently in its sixth year of operation, and enrollment has grown from 19 members to 300 member roster. Members are assigned to one of two groups which meet on alternating Wednesdays, and a supplemental leadership group is comprised of teenagers who have been active participants for at least one year and have demonstrated leadership skills. Members in the supplemental group attend bimonthly meetings on Thursdays in addition to their Wednesday meetings.

BACKGROUND

The Soaring Eagles Project was developed in response to the need to focus on American Indian youth as identified in the 1984 conference entitled "Indian Leadership in American Society". The premises for the program are based in the growing body of research literature indicating significant psychosocial programs affecting the American Indian population. The available research clearly indicates the great need for culturally sensitive prevention programs to serve children and youth in this population, and the Soaring Eagles program serves to address these needs within the Minneapolis/St. Paul urban community. The Soaring Eagles program is based on four assumptions drawn from the existing research, and these assumptions and their research support are presented here as the conceptual foundation for the program.

ASSUMPTIONS

1. Alcohol and drug abuse is significantly more prevalent among the American Indian population than any other ethnic group in the United States. Numerous researchers have reported higher rates of alcoholism among this population (eg. Beauvais & LaBoueff, 1985), and some estimates reflect a rate of alcoholism that is two times the national average (U.S. Dept. of Health, Education, & Welfare, 1970). Drug and alcohol use among adolescents is also a significant problem, and an extensive epidemiological study indicates that Indian youth tend to use all drugs earlier and substantially more often than their non-Indian peers (Beauvais, Oetting, & Edwards, 1985a, 1985b).

2. The significantly higher rates of drug and alcohol use result in numerous related problems that may result in a pervasive and damaging impact on Indian families. For example, the suicide rate among American Indians is two times that of the U.S. general population (Hoehkirchen & Jilek, 1985), and it is estimated that at least 75% of the suicides are alcohol related (U.S Center for Studies of Crime and Delinquency, 1973, Willer & Vokes, 1989). Alcohol abuse is identified as a direct factor for four of the top ten causes of death among American Indians (Vanderwaagen et al., 1986) and chemical use is considered to contribute indirectly to the other leading causes of death. American Indian children have approximately ten times the likelihood of being born with Fetal Alcohol Syndrome (Aase, 1981), and parental chemical abuse also results in increased rates of physical and sexual abuse and neglect (Wilker & Vokes, 1989). Urban American Indian youth are taken in police custody for violations committed under chemical influence at least four times as often as other ethnic minority groups (Jepson, Strauss, & Harris, 1977), and delinquency and arrest rates of American Indians are among the highest of any ethnic group (U.S. Department of Justice, 1976).

3. American Indian children constitute a high risk population based on the prevalence and severity of the problems outlined in the first two assumptions. Indian youth are more likely to have parents with chemical abuse problems, and

they are more likely to be victims of abuse or neglect. The high school dropout rate for American Indian youth in the (Minneapolis Public Schools Profiles of Performance), and the unemployment rate among the population is consistently very high (U.S. Senate Select Committee on Indian Affairs, 1985). The pregnancy rate for American Indian girls aged 10-19 is twice that of non-Indian girls, and American Indian youth are three times more likely to die in accidents (Willer & Vokes, 1989).

4. Based on the integration of the first three assumptions, there is a glaring, obvious need for prevention programs to serve this population. The Soaring Eagles Project is a culturally sensitive program based on research in the area of substance abuse prevention, and the program is designed to provide long-term support to the members. The major components of the program are presented in the next section, and include the general schedule of activities.

MAJOR COMPONENTS

The basic structure of the program consists of bimonthly group meetings, weekly educational enrichment programs, monthly family potluck events, and an annual family retreat. The four major components of the program are listed below, and the research indicating their effectiveness is also presented.

1. Since American Indian children are more likely to exhibit poor academic achievement, strong emphasis and value is placed on education in the Soaring Eagles program to facilitate better school adjustment and encourage adherence to the traditional American Indian values of knowledge and wisdom. The education programs include American Indian Youth Study Time on Saturday mornings, three weekly Progressive Academic Support System classes for students who are far below grade level, and the Challenge to Achievement program where participants are rewarded financially for receiving good grades. Education is clearly an important step toward enhancing the quality of life for American Indian families, and also serves as a protective factor against poverty, unemployment, chemical abuse, and delinquency.

2. The goal of developing a positive social support network is accomplished through group meetings and activities, and is designed to provide the youth with competent adult role models, emotional support, and a positive peer group. Research indicates that there is intense peer pressure among Indian youth to participate and drink heavily in drinking groups, (Ferguson, 1970; Lurie, 1972;) group for youth where they learn it is possible to socialize and have fun without drinking.

3. Program activities are designated to improve self-esteem and social skills by providing opportunities for interaction with peers in a supportive social environment, and to enhance self-identity and feelings of self-worth through exposure to cultural traditions and beliefs. LaFramboise and Rowe (1983) propose that skills training is an effective means of facilitating better mental health functioning for American Indians, and Bach and Bernstein (1981) contend that a major component of any prevention programs for American Indian youth should emphasize a social learning model that builds self-esteem and coping skills. Providing exposure to cultural traditions and beliefs is also a necessary component of prevention programs for American Indian youth (Lewis 1982; LaFramboise, 1988), and strong cultural identification can help to inoculate youths against substance abuse (May, 1986; Oetting, Beauvais, Edwards, Waters, Velarde, & Goldstein, 1982). Additionally, the work of Spero Manson (1982) and Yvonne Red Horse (1982) supports the importance of developing a cultural network model of support services for American Indian adolescents.

4. The fourth aspect of the Soaring Eagles Project involves the integration of mental health services into the development and procedures of the program. Since mental health is the focus of this conference strand, the role of mental health services in this program is expanded and discussed in the next section.

MENTAL HEALTH ISSUES

The provision of mental health services to members and their families is a growing and important aspect of the Soaring Eagles Prevention Project. Direct services are provided by the staff child psychologist, and indirect services are provided by all staff. The direct services available include annual psychoeducational screenings, consultation with

schools, community agencies, and program staff, child and family psychotherapy, and parent support and counseling. Each of these services will be further described in this section, and attention will be given to exploring the ways in which mental health issues are identified and addressed within the context of the program.

The psychoeducational screening is administered annually to all Soaring Eagles members. The assessments are conducted for the purposes of providing data on all members, and the data is utilized for screening any social/emotional/ behavioral/familial/academic difficulties, as well as for evaluation and outcome purposes. Program evaluation and outcome data are based on overall group performance, and selected findings are presented in the psychoeducational assessment data report that follows this chapter. The present chapter will address the purpose of the assessments and relevance of the results as they pertain to individual performance and needs.

In terms of screening for academic strengths and weaknessess, the measures utilized include an individually administered achievement test (Peabody Individual Achievement Test ((PIAT)) Dunn and Markwardt, 1970), and an abbreviated intelligence test (Wechsler Intellignece Scale for Children-Revised ((WISC-R)) Wechsler, 1974). The PIAT includes standardized scores based on a normative sample, and children performing at or below the 25th percentile compared to the normative sample on any subtest are referred for supplemental academic programs offered by Soaring Eagles. However, it is important to note that the normative sample for the original PIAT is <u>not</u> representative in terms of American Indians, and many items appear to be culturally insensitive and biased. The PIAT was normed on a stratified sample from the general population, so performance scores are based on comparisons to children who were most likely not American Indian. Therefore, the results are utilized <u>only</u> for general screening purposes to identify children who may benefit from Soaring Eagles educational programs, and results are <u>not</u> used to make any educational decisions in terms of placement in special classes or any other potentially damaging misuse of the data. The same restrictions on use of the data apply to the WISC-R scores on the vocabulary and block design subtest, and the possibility of test bias is guarded by interpretation with caution. Results of the PIAT and WISC-R are used primarily to 1) Identify children who appear to be underachieving relative to their level of cognitive abilities, 2) Identify children with significant discrepancies between verbal and performance skills, and 3) Identify children who receive exceptionally high scores on the PIAT or WISC-R. In cases where a child appears to need additional remedial or gifted programming, parents are contacted and encouraged to request that their child be assessed by the school. Consultation with the school is offered to help parents ensure that their child receives a fair and accurate assessment of his/her academic needs.

Familial issues are addressed in the Soaring Eagles Survey, and interview administered to all members. The most common problems revealed in these interviews include physical and sexual abuse, neglect, parental alcohol and drug abuse, domestic violence, and absent fathers. In cases of physical abuse, sexual abuse, or neglect, the interviewer attempts to gather as much information as possible from the child in order to assess the need for a report to child protection services. The interviewers are mandated reporters, and any case meeting the criteria for abuse or neglect is reported to the authorities. However, it is the experience of the clinicians that a report to child protection is in no way a guarantee of the child's future safety, and this lapse in the system is mended by maintaining ongoing contact with the child in informal settings such as a group meeting. When the child reveals the abuse, he/she is praised for being brave enough to talk about it and is encouraged to continue informing the interviewer whenever an incident occurs. The child is told that the staff are concerned about his/her safety, and therefore the clinician will want to check in with the child regularly to discuss safety issues. The informal contacts include asking questions such as "Have you been safe lately?", "How is your mom/dad doing this week?", "Is there anything you need to tell me", and "Remember to stop by and see me so I can know how you're doing." The frequency and consistency of the informal contacts is considered vital to developing a trusting relationship with the child, and is particularly useful in families where the parents refuse any mental health services for themselves or their children. Since the families with the highest degree of dysfunction are often the least likely to allow any intervention, services are more easily accepted when they are provided within the context of a broad program that is not viewed as intrusive.

In addition to child abuse, the most commonly reported parental problems include alcohol/drug abuse and domestic violence. The children in the program often report parental chemical abuse problems, and positive responses to these interview questions are viewed as opportunities to discuss the child's concerns and the impact of the chemical abuse on the child and family. If a child is unable or unwilling to discuss the issue, he/she is encouraged to come back and see the psychologist whenever he/she feels ready to discuss it. Chemical abuse is a very sensitive issue in some families, and the children's defenses are respected during the assessment process because they serve the purpose of helping the child cope with the distress. Children who do reveal parental chemical abuse are reassured that they are not alone in their problem, and that many children in the program have similar difficulties at home. Referrals are made to support groups for children, such as "Children are People", and the issues are also addressed in group activities during Soaring Eagles meetings.

When a child reveals current domestic abuse, the clinician asks the child for permission to call the parent being victimized, usually the mother to express concern for her safety. The child is usually relieved to have the burden placed on an adult, and a child rarely refuses permission to call the parent. Phone calls to the parent provide the opportunity to express concern felt by both the child and the psychologist, and also provide a connection on which to build a relationship with the parent. Referrals for the parents are offered when appropriate.

Social/emotional/behavioral difficulties are assessed through the interview, the Child Depression Inventory (Kovacs & Beck, 1977), kinetic house-tree-person-family drawings, the Piers-Harris Children's Self-Concept Scale, and the Symptom Check List 90 for teenagers. When a child exhibits significant maladjustment on a combination of these measures, the parent is called and asked to meet with the psychologist to go over the assessment results. Feedback is offered in person, and helps to facilitate an open discussion about the child and the family. Parents are generally relieved to hear options available for helping the child, and a crucial element appears to be the fact that a professional makes the overture to the parent rather than the parent needing to find and contact available resources. For families experiencing economic difficulties and extreme levels of stress, having someone else reach out and demonstrate concern for the family serves to facilitate a stronger compliance with recommendations and treatment.

Whenever appropriate, individual and family psychotherapy services are offered to the family. Recommendations for treatment are presented in cases of abuse where the trauma has not been resolved, in cases of maladjustment that is seriously impairing functioning at school, home, or in the community, and in cases were family dysfunction is severe. While every effort is made to engage the parents in the therapy, a child is not denied services if parental involvement is refused. Although it is not ideal to treat the child without treating the parents, it is the opinion of this clinician that it would be unfair to deny a child help on the basis of having uncooperative parents. Parental consent to treat the child is necessary, and is generally granted by most parents. Even when a parent denies consent to treat the child, the child remains in the program and the needed support is provided in more subtle ways through the project staff and group leaders.

Consultation with program staff allows for mental health concerns to be integrated into the content and process of the program, as well as ensuring that indirect psychological services are reaching all members. Since the reality of having a high-risk population of 300 youth and only one full-time psychologist indicates that individual services cannot be provided to all members, consultation and staff training facilities developing and conducting the program with psychological and developmental issues in mind. Staff members are given training in issues such as recognizing and reporting abuse, child and adolescent development, and discipline, among others. Group leaders are able to observe more closely those children identified by the psychologist, and they provide extra attention and support to children in need of help. Soaring Eagles meetings are not intended to serve as group psychotherapy, and the focus is placed on developing a positive support network for the youth through a variety of social and cultural activities. Therefore, mental health services are incorporated through consultation, which results in a holistic service delivery model that is less intrusive and more easily accepted by the clients.

PSYCHOEDUCATIONAL ASSESSMENT DATA

One of the objectives of the annual assessments is to collect a documented database of the members served by the program. While an exhaustive list of all findings will not be attempted, selected data tables and descriptive summary statements are presented (see Appendix A, B, & C) to assist in the description of members and their lives.

SUMMARY DESCRIPTIVE STATEMENTS

1. For members who completed their initial assessment in 1988, 80.9% have average or above average cognitive abilities as measured by an abbreviated form of the WISC-R.

2. For the 1988 members, 31% received total PIAT scores that fall in the bottom 25% compared to age-mates.

3. Therefore, while 1/5 of the sample is of below average intelligence (as measured by the WISC-R), almost 1/3 of the sample is achieving at a level far below age level.

4. Among the 1988 cohort, 4 children score in the borderline/mentally handicapped range on the WISC-R.

5. Among all members (new and returning) tested in 1988, 23% are experiencing moderate to severe depression as measured by the Child Depression Inventory.

6. Among all members active in 1990, 84% maintained or improved their report card grades.

MEMBERS RESPONSES: "WHAT SOARING EAGLES MEANS TO ME"

"Soaring Eagles helped me realize what a privilege it was (and is!) to be an Indian and learn to be proud of it. My life is with my friends and 'family' at Soaring Eagles. If that were taken away from all of us Native American kids, what would we do? I know what I would do! I would bring it back, so my people would learn the love of our communities and spread that love so others can feel it. Because of that love, today I am a leader and will be even stronger among my people and peers. Soaring Eagles made me <u>proud</u> and for that I am truly thankful." (14 year old girl)

"While participating in the Soaring Eagles group, I have learned about my background, learned leadership skills and to be a good role model for people in my community. It has also provided me with a job in which I help out with programs and help other employees with work they have. I have also set goals for myself and work towards them, and have learned to take on new responsibilities. However, one of the most important things to me that I have discovered is...I have made many good friends that help me out and encourage me when I need it." (15 year old boy)

"I wish they had something like Soaring Eagles up here because there is nothing to do other than get into trouble. I really miss going to Soaring Eagles. Lately I have been trying to keep my grades up and stay out of trouble. When I wear my Soaring Eagles jacket around here everyone asks me what is Soaring Eagles. When the teachers ask me I just show them the brochure I still have... but when the kids ask me I not only show them the brochure but I also tell them about all the opportunities you guys gave me. I plan to return to Minneapolis as soon as school gets out, and maybe if I'm lucky I will get to stay up there for school next year. My Mom says it all depends on my grades so every time I think of Soaring Eagles I just know I have to work a little harder. I will always be a dedicated member of Soaring Eagles no matter what!!!" (14 year old girl who moved from the area)

CONCLUSION

The Soaring Eagles Prevention Project is funded through August, 1992 by the Office of Substance Abuse Prevention. Efforts are currently in progress to obtain research funding for the development of a control group in order to facilitate a more objective, scientific approach to program evaluation and outcome. There is clearly a great need for empirical data on prevention programs, and developing a solid research component is a priority goal for this project. Data gathered through scientific means is necessary to control threats to validity during program evaluation, and the results will further the field by providing empirical data on the population being served and on the effectiveness of various strategies and methods. Soaring Eagles staff are committed to providing enduring and consistent services to all members, and the development of positive, secure relationships between staff and members is viewed as a critical aspect of the program. Research indicates that the

presence of even one important adult who demonstrates concern for the child can serve as a protective factor for otherwise high-risk children, and the Soaring Eagles program attempts to build bridges to reach youth who represent isolated islands. As all staff are reminded by the program director, "We are in this for the marathon, not the sprint."

ENROLLMENT

YEAR	NEW MEMBERS	TOTAL MEMBERS
1985	54	54
1986	54	108
1987	10	112
1988	28	140
1989	8	148
1990	92	240
1991	60	300

TABLE 1: SURVEY RESULTS: RISK FACTORS (% responding yes)

Question	3-10 year olds	11-18 year olds
Have you ever...		
...been in foster care	26%	29%
...been homeless or left by parents	24%	10%
...run away from home	7%	20%
...been in trouble with the law	*	25%
...been suspended/expelled	*	33%
...had a parent in CD treatment	*	31%

* Question not asked

TABLE 2: FAMILIAL ALCOHOL ABUSE

Relatives youth identifies as drinking too much	3-10 year olds	11-18 year olds
mother	27%	38%
father	34%	28%
aunt	30%	33%
uncle	40%	42%
grandmother	20%	18%
grandfather	15%	6%
sister	3%	18%
brother	6%	12%
cousin	10%	24%

TABLE 3: CHEMICAL USE: YOUTHS 11 AND OLDER

Substance	Current Use	Has ever tried
alcohol	10%	39%
marijuana	6%	26%
cocaine	0%	2%
inhalants	0%	8%
other	0%	4%

TABLE 4: EXPOSURE TO CRIME/VIOLENCE

Event (Have you seen someone...)	3-10 year olds	11-18 year olds
...get robbed	25%	17%
...get beat up	62%	62%
...get stabbed	14%	14%
...get shot	16%	12%
...break property	43%	38%
...hurt themself	26%	31%

TABLE 6:
ACHIEVEMENT: RANGE OF SOARING EAGLE'S STANDARD SCORES ON PEABODY INDIVIDUAL ACHIEVEMENT TEST

Subtest	Minimum Percentile	Maximum Percentile	Mean
Math	4	99	100.98
Reading Recognition	2	99	97.85
Reading Comp.	1	99	97.85
Spelling	2	99	97.99

NOTE: While the mean score for this sample is comparable to the normative sample, the range across this sample is extremely wide, including children in the gifted range and others in the mentally handicapped range. Normative sample: X=100, s.d.=15.

TABLE 7:
COGNITIVE ABILITY: RANGE OF SCALED SCORES ON WECHSLER INTELLIGENCE SCALE FOR CHILDREN-REVISED

BLOCK DESIGN

Score	Frequency	Score	Frequency
2	1	12	14
5	1	13	10
6	2	14	5
7	6	15	3
8	2	16	2
9	6	18	3
10	13	19	5
11	16		

Normative Sample: X=10, s.d.=3
Soaring Eagles Sample: X=11.58, s.d.=3.29

VOCABULARY

Score	Frequency	Score	Frequency
3	1		
4	2	12	4
5	1	13	4
6	6	14	8
7	11	15	2
8	11	16	1
9	11	18	1
10	14	19	1
11	9		

Normative Sample: X=10, s.d.=3
Soaring Eagles Sample: X=9.93, s.d.=3.22
NOTE: As was noted with the achievement results, the scaled WISC-R scores for this sample include scores significantly lower and higher than the mean.

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SOLID GROUND

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SOLID GROUND

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INTRODUCTION

Solid Ground initially began in Lansing as a result of the apparent suicide of a highly successful student. (It was actually an accident.) At that time Rocky Basil, the eventual founder of Solid Ground, asked Cheryl Ebeling, a counselor, and George Ebeling, a psychologist, and both long-time friend of Rocky Basil, to help him with the youth who were grieving at the funeral. Rocky was concerned that others might attempt suicide in a "follow-the-leader fashion." The meetings with the youth were held in various rooms of the mortuary and continued for two days.

Following the funeral and the meetings, the youth involved asked Rocky if they could continue to meet. From the beginning Rocky Basil has since expanded the Solid Ground self-help groups into three states. We have continued to serve as consultants to those groups and have been called on as needed. There has been no funding for this process other than that which local agencies have been willing to contribute. The process has been a strictly volunteer process.

Solid Ground is not run by professionals. It is run by lay people who have additional training. It has consistently emphasized, however, that certain problems require the assistance of a professional. The students or the leaders will make a referral and help the individual to keep the appointment.

We offered our first training in Solid Ground at our Family Unity Conference, which was held in a local motel/conference center. At that time approximately 45 Indian youth were trained. We continued the process by meeting twice a month for two hours and held a second training for a additional 60 Indian youth. Currently, over 120 youth have been trained in Solid Ground, a figure which represents the majority of youth who live on or near the Saginaw Chippewa Reservation. We are aware of a number of incidents of suicide that did not occur as a result of peer intervention.

The second year of training included 19 youth from Bay Mills Indian reservation who were also trained in the techniques used in Solid Ground. They also formed an on-going group that has been meeting twice a month and has proven very successful.

Solid Ground is a peer intervention/prevention group process. Although it was first created to be used for suicide prevention, it has also been used for intervention in drug abuse, sexual abuse, and physical abuse cases, as well as for the normal crises that occur in the lives of all teenagers.

The initial training consists of three days of in-depth peer interaction with the presentation of didactic material, discussing, and role playing.. It is preferable that the training occur in a setting where the youth can stay overnight. In some situations training has occurred in high school gyms and church basements.

The training during the first year was limited to Junior High School and High School students. In the second year we included a younger age group from the elementary schools, but this proved not as successful as we had hoped. It is now our recommendation that the training be limited to youth ages 13 to 20.

It is preferable to have at least one adult for every ten youth. Generally, this results in two trainers for every group as well as several students who have participated in other Solid Ground groups.

The training is very intense and fun activities need to be planned for the evenings. This serves not only for providing relaxation but also for encouraging the continuation of the trust, warmth, and support in a more natural environment. The training session begins with all the youth meeting together. The trainers, materials, schedules, etc. are introduced and presented at this time. The youth then break up into smaller groups, depending upon the total number of youth who have begun training.

The small groups should consist of approximately ten to twenty youth. During these small group meetings the youth are taught the skills of listening, communication, and giving feedback. One skill is taught and practiced and then another skill is added and practiced. This occurs through the process called "working". "Working" consists of four

individuals: one serving as speaker, one as listener, and two for feedback. After "working" all the members of the "small groups" are allowed to exchange feedback and ask questions.

Because youth will have identified some of their issues during the training, it is essential that a support system be devised. In the majority of instances this is accomplished through on-going group meetings. We scheduled our groups to meet twice a month for two hours each. Many other Solid Ground groups meet weekly for several hours. These meetings begin with a check-in: introducing oneself and sharing how one feels. Then, we go to "work". In the beginning, it may be necessary for leaders to introduce non-threatening occurrences that occur routinely within the life of a teen to serve as "work" topics.

It is possible for a youth to become a Solid Ground trainer. This is accomplished by attending the initial training, the regular meetings, and completing a two-day trainers training.

Solid Ground training has prevented youth suicides, has identified youth who have been sexually molested and/or physically abused, and has taught youth that they can reach out in times of pain and someone will be there. Usually the first one there is a friend who has learned how to listen, how to identify if more help is needed, and how to help a friend get the help asked for.

When we began the Solid Ground program, we weren't sure whether or not it would work with Indian youth. The youth in our community appeared to be very reluctant to share their feelings and openly discuss any difficulties they were experiencing; however, we were pleasantly surprised. As is true with any group, the degree of participation ran the gamut from no overt participation to disclosures of sexual abuse. The youth learned how to give each other comfort and support. As one fifteen-year-old boy said through his tears, "This is the first time I've ever been hugged." They learned how to help each other sort out feelings, and events, and thoughts. For example, one girl learned that she was taking out her anger on her mother, even though her mother actually had nothing to do with her difficulty. They learned how to help someone constructively solve a problem - one boy began to learn that his answers didn't come from a bottle but from talking out his problems with someone who could help him.

We knew the youth carried home new knowledge and skills when one Saturday three weeks after the training a sixteen-year-old boy called us to say that he was getting in over his head and needed help. He was with a father and his young daughter; the father had just been told by his daughter that she had been sexually molested.

We knew when a fourteen-year-old helped her seven-year-old cousin with telling about being sexually molested, and when she helped the other girls in the family - the adults didn't know what to do.

We knew when an eighteen-year-old was able to talk about his rape as a child, was able to tell his parents, was able to stop drinking and taking drugs, was able to tell his parents that he loved them, and finally, that all he wanted was for them to love him.

This is a manual used for Solid Ground participants.

PEER GROUP TRAINING MANUAL

A. Ground Rules
   1. Confidentiality
   2. No permissions---
   3. If a person is being abused, it must be reported
   4. No distractions -
      a. internal
      b. external
      c. speaker-
   5. "I don't count."
   6. Don't be judgmental.
   7. I don't solve problems.

B. Cautions
   1. We are not therapists or psychologists.
   2. Stay with the model, you can't hurt anyone.
   3. This model will be mistaken for something else by some people.
   4. Some people fear contact-hugs are not for all people.

C. Responsibilities
   1. Speaker

Everyone reacts in his own way. Because of this, you the speaker must:

   a. Describe to me what your problem is (paint me a picture).
   b. Tell me what your feelings are because of your problem.
   c. Stay with the problem.

   2. Because my friend is hurting or in a crisis, he/she can't think of solutions. "If my friend is into strong feelings, my friend can't think." I the listener must:

      a. help my friend paint the picture
      b. help my friend identify feelings
      c. keep my friend centered on his problem
      d. feedback feelings and the picture as you understand it
      e. help your friend identify solutions to the problem
      f. be sure your encounter is closed before you separate from your friend

D. Body language is important to keep interaction going.

   1. Positive
      a. lean toward your friend
      b. eye contact
   2. Negative
      a. pulling away
      b. little or no eye contact
      c. pulling down eyebrows
      d. crossing of arms
      e. inappropriate smile

E. Reflecting feelings

   1. Reflect obvious feelings - Attached to cause
   2. Risk hidden feelings - Attached to cause

(Keep reflections short and present them one at a time.)

F. Voice
   1. Reflect feelings with proper vocal intensity
   2. Match voice and feeling

G. Closing
   1. solutions or options to solving the problem are identified
   2. your friend has work to do
      a. behavior change
      b. talk to someone
   3. your voice changes to bring your friend out of the feelings he/she is having
   4. you and your friend can smile
   5. you ask your friend, "is it ok to stop here?

Your friend comes to you:
   1. with a problem, in crisis
   2. have your friend paint the picture
   3. identify feelings and feel these feelings
   4. paint the picture back for your friend with feelings in the appropriate places
   5. have your friend come up with options or solutions to the picture
   6. you can contribute options to be accepted or rejected
   7. help identify the best options
   8. reflect option and work needed to correct problem in questions
   9. Close

(See Appendix A.)

TRAINERS' TRAINING MANUAL

A Brief Introduction

If a person is trained to be a doctor, will they become a good doctor? If a person is elected to be a judge, will they be a fair and impartial judge? No one can predict for sure; however, everyone possesses the ability to help their fellow human beings. All of us have some skill at listening and understanding another person's problems.

Solid Ground, utilizing some new and some old techniques, helps teach people, specifically teenagers, how to help their friends when they experience a crisis. It is a non-judgmental model that enables the individual to solve his/her own problems with guidance from the person helping.

While some of the model is based on the empathy training utilized by Carl Rogers, it is much more than that and utilizes skills young adults can use. It consists of a basic three-day experimental training with lectures, role playing, and didactic material designed to elicit communication skills quickly and easily. There are an additional two days of training for trainers - those who wish to train others in the model.

The training teaches communication skill that will help young and old deal with problems such as suicide, drug overdose, legal problems, family problems, school problems, peer problems, etc. It is also applicable in their own relationships, since it is a problem solving model.

What Is A Problem?

When young adults attempt to solve a problem, they often lack the experience and skills to do so. First, what is a problem? It is something a person feels uncomfortable with. It can vary from being mildly upset to being overcome by the emotions that the young people are feeling. They feel bad.

For the purposes of this paper, emotions and feelings will be used interchangeably as synonyms. The important issue is that the emotions or feelings occur right now and here. If you feel sad - that's it, you feel sad.

A problem becomes evident when something occurs, when there is a choice, or a change, and someone has an emotion or feeling about it. Further, there are at least two parts to understand a problem: first, what is happening and second, what the feelings about it are.

The purpose of helping someone is to help the person solve the problem for themselves. It is not to solve the problem for themselves. It is not to solve the problem for the person. The purpose of this program is to help the speaker learn to solve problems for themselves.

In real life there are often only two people involved when a problem occurs - the speaker and the listener. (In training, there are four people involved.) The goal for the listener is to help the speaker to decide what to do about the problem.

THE HELPING PROCESS

To help organize the process, five steps are posited:

1. The speaker owns his/her emotions.
2. The speaker owns the important issues in the problem - what they value.
3. The speaker decides what to do.
4. The speaker does what he decides to do.
5. The speaker sees how his decision works - often reports back to the group or even the helping friend.

In the first step, the speaker knows that there is a problem because there is an unpleasant feeling or discomfort. It is possible, however, that he does not know how strong the feelings or emotions are. He or she may not realize all of the aspects of the problem that are creating the feelings and emotions. As a listener you help them to understand their feelings and emotions. You also help to connect these feelings to the problem, especially the changes or choices they are facing.

As the speaker talks, he begins to understand how what he has been taught in the past, what he learned, and what he is experiencing, are affecting him or her now. When this is completed, the speaker should have a grasp of what his problem is, what his feelings are, and what past learning may have influenced how the speaker feels.

The speaker may now be ready to enter the problem-solving phase. In this phase the speaker decides what to do - it is his/her decision, not the listener's. While the listener may offer suggestions, the speaker must choose what makes the most sense and fits best into his/her life pattern. It is important for the speaker not to talk the listener into something that he/she believes would be best.

Once the speaker makes his decision to do something, he/she goes and does it. If it does not work, the process starts again.

In the last step the speaker finds out how the decision is working. If his/her emotions are favorable, then the decision has worked, if not, then the process is begun again. Either way, the speaker can continue to utilize this process for other decisions in his/her life.

THE PROCESS

The communication process uses empathy as its primary system of communication. Empathy as a helping process was created by Carl Rogers and has been used in social services, drug treatment centers, and crisis centers for years.

It is a non-judgmental system of communication. This obviously does not mean that you don't agree or disagree with the ideas being offered. It does mean, however, that you don't give advice or your ideas if inappropriate. This is accomplished by assuming ownership of your own idea, and not theirs.

To make the empathy process work, the listener utilizes declarative sentences or statements. Questions can cause someone who is having feelings to have a defensive reaction; whereas declarative statements help the speaker to seek out his/her own insights. A question can also lead the speaker to believe that you are only interested in procuring information and not in them as a person. It may lead the speaker not to trust the listener. Further, it will ask the speaker to stop feeling and start thinking, losing touch with his/her feelings.

A declarative sentence is simply a statement that repeats what the speaker has said. It also can be a question embedded in a declarative sentence. Mostly, it is reflective in nature. The purpose of the empathic response is to explore what is called the deep structure of an individual - their beliefs and understandings of the speaker. It is also to help the speaker to explore his/her own feelings as far as he/she wants to go.

HELPING THE SPEAKER TO EXPLORE HIS DEEP STRUCTURE

In order to explore how a person sees, feels, hears and understands their world, it is necessary, once the emotions about the problem have been explored, to clarify his/her view of the problem and the surrounding characteristics of the problem - sometimes called values. Open-ended questions are used to complete this process. Open-ended questions ask for responses, as opposed to close-ended questions that ask for a yes or no, or a specific fact such as a name. Open-ended questions keep the conversation going and help the speaker to clarify his/her views about the problem - their deep structure of understanding, how he/she perceives the problem.

HELPING THE SPEAKER DECIDE WHAT TO DO

The next step is problem-solving. This process helps the speaker to decide, on the basis of his/her own values and beliefs, how to solve the problem. You help the speaker see, feel and hear what the speaker really thinks about the changes about to be made.

During this step you are more active than previously. You may already have an idea of what the speaker wants to do, but remember, it must be the speaker's idea. Don't try to talk the speaker into your pet idea. Don't be judgmental or lecture. Remember, the speaker has solved problems in the past and can do so again. By this time you have a complete picture of the speaker's problem - you can paint it out for the speaker.

TEN STEPS TO CLARIFYING THE PROBLEM

1. Sum up the problem to ensure that you and he/she are talking about the same thing.
2. Help the speaker identify his/her goal.
3. Help the speaker identify how he/she keeps from solving the problem.
4. Help the speaker identify the price the speaker pays for not solving the problem.
5. What are the rewards the speaker gets from not solving the problem?
6. How does the speaker feel about solving the problem?
7. What are the different ways he/she can solve the problem?
8. What are the good and bad aspects of the solution the speaker has decided on?
9. How does the speaker feel about the solution?
10. How could the speaker sabotage the solution?

THE ACTUAL CHANGE PROCESS

If the speaker decides to change, then you also may be able to break the change down into chunks or small pieces that the speaker can handle. What is he/she going to do? When is he/she going to do it? How is he/she going to do it? How much

success will it take to keep going? how will he/she know about the success? What is he/she going to do if the solution doesn't work?

FEEDBACK

Few people are trained in the act of giving and receiving feedback about themselves We often become defensive, tune out, shake our head yes, and hope we can get away as soon as possible. We discount it; we get angry or sad or experience a variety of feelings; we become adaptive, saying yes when we really mean no. Most of the time, we forget it or obsessively dwell on it. None of these is useful and rarely does either participant accomplish the original goal - to help someone solve a problem.

In this situation feedback is given to help the listener better develop their skills as a listener. The feedback, in order to help the listener, must be specific and behavioral in nature - something that can be changed. In general, positive feedback will lead more to growth than to negative feedback. When feedback is given, it should focus on the description of the behavior of the listener and the effects that you believe it is having on the speaker. Never give feedback on what the listener is as a person.

Good feedback is clear, specific, contains examples, and usually should offer a suggestion for a different behavior. Never give feedback to a listener if they are upset or for some reason can't hear it. Further, when you are finished giving the feedback ask the listener what they heard - to summarize it in their own words. This is to check that what you delivered and what they heard are the same.

TRAINER SCALES
REFLECTIVE SCALES

At the most, the listener is able to use reflective responses which add to the speaker's self-understanding, by identifying his/her feelings and deep structure or values which are central to the speaker's problems. He/she communicates a full awareness of what the speaker is experiencing.

RESPECT SCALES

There is a deep respect and warmth communicated by the listener for the speaker as a person with full rights as a free individual. The speaker is free to be himself/herself. The listener also shows the same regard for himself/herself, freely and deeply being himself/herself without retarding the growth of the speaker.

FEEDBACK SCALES

When feedback is offered the listener is clearly at ease and eager to improve his/her own abilities and capabilities. He/she wants and uses feedback to improve their own abilities.

THIS LOOKS LIKE A SOMEWHAT COMPLICATED TRAINING MANUAL, BUT IT IS NOT. IT IS PRESENTED IN A DIFFERENT FORMAT FOR THE PEER GROUP TRAINING.

FROM A SOLID GROUND PARTICIPANT, AGE 14

After the general orientation, the most frightening, yet enlightening experience, took place. We were separated into small groups of kids in a room. Before, we were protected by the mass of impersonal chit-chat, now we were face to face and I was afraid. I didn't know anyone, but it seemed like everyone else did. Luckily, another girl there was like me, so we began to talk, but I still felt separated. The day started with mindless get-to-know-you games, which never work. Then Rocky, a man with a large presence amongst us, began to teach us about listening. He showed us how to take a person's life, like a puzzle, tear it down, find the problem, and fix it. We talked about how to deal with grief, death, suicide, abuse, etc. Basic concepts were easily understood as long as they weren't about you. But then Rocky did it. We had to take his words and use them. There were four people: a person with a problem, his supporter; "the speaker" and the feedbacker. I was the first victim. I had to tell a problem I was having, but I wimped out. This was not going to work, I thought. We can't talk about ourselves. At this point something amazing happened. One of the girls sat down and started to talk about her childhood. The longer she

talked, the more truth came out. She was crying and crying, and wouldn't stop. She was sexually abused by her brother's friends. I was in shock, and a dark cloud covered the room and for the first time they were more than simply faces. More girls started to cry, and their past, which they had tucked away, reappeared. As the girl cried, a boy was summoned to support her. I could tell that he was not used to it, but no one could have made her feel better. Then, all of us as one, talked about our feelings, feelings that we never wanted to tell anyone, but we did and it felt great. For the rest of the night and the next day, I was no longer afraid. The people I thought that would never open, talked. One of those people was me. I can still remember how wonderful I felt; I still remember how wonderful we all felt, and it showed in every one of my pictures.

The Solid Ground training opened my eyes to a lot of things. I learned that people do have problems, but, more importantly, that they want to talk about them. I learned how to listen and how to help and that a stranger can become your confidant. The rest - the bonding, the sharing, the caring, the love that I have never felt - is unexplainable. But, it was there, and I can still feel it.

"STRENGTHENING THE CIRCLE"
AND
"FAMILY FIRST"

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"STRENGTHENING THE CIRCLE" & "FAMILY FIRST"

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The Circle is the Indian way of life. Everything is a non-ending process: always beginning, never ending. The Family is a circle from newborn to elders. Tradition, beliefs, and values are passed on from the elders through the generations. One day our children will be our elders and our teachers - that is why our children are cherished gifts. Children are gifts from our Creator.

The purpose of the Family Services Department of the Minnesota Indian Women's Resource Center (MIWRC) is to strengthen Indian families by building on the tradition of the natural and extended family systems by preventing children from substitute care and keeping children living together with their family unit. MIWRC Family Service program is staffed by seven full-time positions; four Family-based Advocates, two Families First Advocates, and a full time supervisor. The direct services staff are persons with many years of experience working with Indian families. This presentation is intended to share MIWRC's knowledge and experience in preserving and strengthening the circle of the family, thereby working toward the prevention of child abuse and neglect. Family Services Department is made up of two programs, Families First and Family-Based.

FAMILIES FIRST

Families First of Minnesota is an intensive, in-home crisis intervention and family education program. It is funded under a grant from the Minnesota Department of Human Services and is designed to assist families in coping with immediate crisis which would result in the out-of-home placement of one or more children in the family. The goal of the service is to reduce the unnecessary removal of children from families, while not jeopardizing the safety of the children. A primary aim is to increase social service effectiveness in working with families of color. MIWRC is one of the four Hennepin County agencies funded through this grant.

The services are an integral part of an initial Family Preservation Program. Family Preservation services are public or private social and mental health services that reach families and children unserved by other approaches. They are based on the beliefs:

- Children need families
- Troubled families can change
- A crisis is an opportunity for change
- Inappropriate intervention can do harm
- Power to change resides within the family
- Services must be culturally appropriate

Services are delivered in the family home and community. Family workers are on call 24 hours a day and work intensively (5-15 hours a week) with a family for up to four weeks. Families First workers work a flexible schedule that meets a family's needs. Services begin within 24 hours of referral and workers are available to families around the clock. Here are some of the offered services: Child development training; parenting education; advocacy; family, individual, and marriage counseling; communication and negotiation skills; job readiness and training, developing helping relationships with community resources; limited financial assistance through FLEX monies; domestic abuse counseling; and self-esteem work.

To be eligible for Families First services, a family must have at least one child in imminent risk of out-of-home placement and be available to receive services in the community. The County Child Protection Agency will assess the need for services and refer appropriate families to the Families First program sites. A major part of the Families First service is linking families to appropriate community resources, family violence programs, family counseling, or parenting groups.

MIWRC FAMILY-BASED PROGRAM

Referrals come to the Family-Based Program from chemical dependency treatment, child protection and courts, other social service agencies, Families First Program, self, and family referrals. Although MIWRC Family-Based Program would like to serve a wide range of cases, problems of chemical dependency, substantiated sexual abuse, and custody issues must be addressed before a family is accepted into the program. Families being pre-assessed for service will have one or both of the following goals:

- Prevention of out-of-home placement.
- Reunification of children in out-of-home placement with their parents and families.

Information gathering is the first part of developing a workable case plan. The Family Advocate gets in touch with the Child Protection worker and gets copies of court documents, existing case plan, ICWA compliance, and other relevant reports and documentation that will assist the Advocate to develop a plan to attain the family's goals. The pre-assessment phase lasts from four to six weeks and if the case is appropriate and the client has been consistent in the pre-assessment phase, we will admit them into the Family-Based Program.

In the next phase of program many services are provided to serve families. These include but are not limited to the following: family case planning; family counseling; client advocacy; parenting and living skills groups; family recreation and leisure activities; exploration of spiritual and traditional values; supervised family visits; transportation; court-advocacy, financial counseling; employment and job development; assistance in getting respite care; daily child care for children while parents are in group or sessions with Advocate, discharge planning, Aftercare planning, and a Feast honoring the graduates of the Family-Based Program.

An important part of the MIWRC Family-Based Program is its culturally specific focus and approach. Parenting groups use the Cherish the Children curriculum which is designed to be used to teach, educate, and encourage traditional Indian values of long ago and incorporate the old into the new. This curriculum consists of eleven clear and concise lesson plans to be used with Indian parents and children. These lesson plans provide information, worksheets, work activities and exercises that over a wide range of topics that include family life of long ago, family life today, self-esteem, nutrition, and other topics. These parenting groups help parents to relearn the traditional ways of teaching and parenting. We believe our children are sacred gifts from the Creator. To instill this belief in our families is one of our primary goals.

Another culturally specific part of the Family-Based Program is the Living Skills component. Group participants are encouraged to request topics they want to discuss or learn about. These topics have included relationships, anger/stress, self-esteem, sober fun, racism and prejudice, relapse and prevention, grieving, battering, sexuality, abandonment, communication, loss, finances and the stresses of poverty, impact of the removal of children from families, and the Indian Child Welfare Act and Minnesota Indian Family Preservation Act. This leads us to another important part of our work and that is the legislation affecting Indian families.

Family-Based and Families First advocates and staff are committed to seeing that the laws that are in place to protect Indian families are upheld. We use advocacy philosophy and work with county agencies that are responsible for placement of children. We help our clients to be informed and knowledgeable of their rights under the law and try to sensitize the agencies with whom they interact.

Re-awakening the strengths and beliefs that are passed through the generations from the old to the new, reaffirms that our circle has not been broken. We are strengthening our circle.

1. Cherish the Children, Priscilla Buffalohead, Robert DesJarlait, published by MIWRC, 1988.

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